



Send to: Group Long Term Disability Claims, P.O. Box 14333, Lexington, KY 40512  
For Customer Service: (800) 538-4583 Fax: (610) 807-8221 Documents can be returned electronically at [www.guardianlife.com/forms](http://www.guardianlife.com/forms).  
Select the "Benefits through work" option and click the "Secure Channel" link to send your private information.

### SECTION 2 - EMPLOYER/PLANHOLDER STATEMENT

#### TO BE COMPLETED BY THE EMPLOYER/PLANHOLDER

Employee/Member Name (Hereafter referred to as claimant)		Social Security Number	Date of Birth
Claimant's Address (Street, City, State, Zip)			

#### INFORMATION ABOUT THE EMPLOYER / PLANHOLDER

Company's Name		Group Policy Number	
Address (Street, City, State, Zip)		Telephone Number	
Name and address of division where claimant works (if different from above)	5-digit claim branch code	Fax Number	

#### INFORMATION ABOUT THE CLAIMANT

Date claimant was hired ____/____/____	Date claimant became insured under this plan ____/____/____	Insurance class:	Schedule at time last worked: ____ hours per day ____ days per week
Was the claimant insured under your prior LTD policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide the effective and termination dates of coverage: ____/____/____ Through ____/____/____			Name of prior carrier:
Has the claimant been terminated? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, date: ____/____/____ Reason:			
Would you be willing to rehire this person? <input type="checkbox"/> Yes <input type="checkbox"/> No Reason:			
Was the claimant on non-discriminatory family leave when disability began? <input type="checkbox"/> Yes <input type="checkbox"/> No Date leave of absence started under Family Leave Act ____/____/____ Did LTD insurance continue while on family leave? <input type="checkbox"/> Yes <input type="checkbox"/> No			

#### INFORMATION NEEDED FOR WITHHOLDING AND REPORTING TAXES

Contributions to the cost of this insurance:  
\_\_\_\_% paid by employer  Check here if claimant elected a bonus back/gross up arrangement (IRS Ruling 2004-55) on a Post Tax basis  
\_\_\_\_% paid by claimant  Pre-Tax  Post-Tax  
Is the LTD benefit exempt from FICA SS?  Yes  No Is the LTD benefit exempt from FICA Medicare?  Yes  No

#### INFORMATION ABOUT THE CLAIM

What was the claimant's regular job?	How long had the claimant been performing his/her regular job?
Was the claimant performing his regular job on his or her last day at work? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, Please explain _____ If no, how long had this claimant been performing this other job? _____	
Last day claimant worked ____/____/____	On that day, did the claimant work a full day? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, how many hours were worked? _____
Reason for leaving work: <input type="checkbox"/> dismissed <input type="checkbox"/> leave of absence <input type="checkbox"/> disability <input type="checkbox"/> resigned <input type="checkbox"/> retired <input type="checkbox"/> layoff	Date claimant is expected/did return to work ____/____/____ Full time? <input type="checkbox"/> Yes <input type="checkbox"/> No Part time? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the claimant's condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has a Workers' Compensation claim or similar claim been filed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, send initial report of illness or injury and award notice.
Name, address and phone number of that benefit provider	

#### INFORMATION ABOUT YOUR PENSION PLAN (Do not complete for maternity claim.)

Do you have a pension plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, what type? (Check as many as applicable) <input type="checkbox"/> Defined Benefit <input type="checkbox"/> 401 K <input type="checkbox"/> Other (specify) <input type="checkbox"/> Defined Contribution <input type="checkbox"/> Profit Sharing
Is the claimant eligible for your pension plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, why?	If eligible, does the claimant participate? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, why?
If the claimant is participating, when is he or she eligible for benefits under the plan? ____/____/____	
Is there a Disability Retirement option available to this claimant? <input type="checkbox"/> Yes <input type="checkbox"/> No	

#### INFORMATION ABOUT YOUR JOB ACCOMMODATION OR RETURN-TO-WORK POLICIES

Does your company have a job-holding policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain _____
What is the name, title, and telephone number of the person we should contact to discuss return to work or job accommodation opportunities?



**INFORMATION ABOUT THE CLAIMANT'S SALARY**

Average earnings excluding bonus, overtime and special compensation as of the most recent redetermination date:

\$ \_\_\_\_\_  Week  Month  Year

Date of last salary increase \_\_\_\_/\_\_\_\_/\_\_\_\_

Claimant is paid:

- hourly  Salary  W2 earnings \_\_\_\_\_
- by partnership  commissions only\*  salary & commissions\*
- salary & bonus\*  salary & commissions\*

\*Please provide average of bonus and commissions for 24 months preceding your plan's most recent redetermination date

Is this claimant eligible for salary continuation?

Yes  No If Yes, what is the weekly amount? \$ \_\_\_\_\_ When did benefits begin? \_\_\_\_/\_\_\_\_/\_\_\_\_ End? \_\_\_\_/\_\_\_\_/\_\_\_\_

Has the claimant filed for Short Term Disability or State Disability benefits?

Yes  No If Yes, what is the weekly amount? \$ \_\_\_\_\_ When did benefits begin? \_\_\_\_/\_\_\_\_/\_\_\_\_ End? \_\_\_\_/\_\_\_\_/\_\_\_\_

List any other sources of income to which the claimant is entitled as a result of this disability:

**Information about the physical aspects of the claimant's job**

Check the items below that relate to the claimant's job and complete the information requested. Use these definitions for the frequency of occurrences in an eight hour day

- **Not Applicable** means the person does not perform this activity
- **Frequently** - 2 ½ hours up to 5 ½ hours
- **Occasionally** – 15 minutes up to 2 ½ hours
- **Continuously** – 5 ½ hours and beyond

**Frequency of Occurrence**

Activity	N/A	Occasionally	Frequently	Continuously
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Working overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Keyboard Use/Repetitive Hand Motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Driving	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activity	Description	Frequency	Weight lbs.
<input type="checkbox"/> Pushing	_____	_____	_____ lbs.
<input type="checkbox"/> Pulling	_____	_____	_____ lbs.
<input type="checkbox"/> Lifting	_____	_____	_____ lbs.
<input type="checkbox"/> Carrying	_____	_____	_____ lbs.

Stress level  Low  Moderate  High  Very high  
 Can the job be performed by alternating sitting and standing?  Yes  No  
 Claimant must use hands for repetitive action such as:

	Right		Left	
Simple grasping	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Firm grasping	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fine manipulation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Use feet for repetitive movements as in operating foot controls:  
 Right  Yes  No Left  Yes  No Both  Yes  No

**REQUIRED ATTACHMENTS AND SIGNATURE**

Please attach a copy of the claimant's job description.  
 If salary is based on a W-2, K-1, 1099 or a similar document, attach a copy of the most recent document.  
 If you have medical information from the claimant's file relating to this disability, please attach copies.  
 If a work related claim is filed, send a copy of the initial report of injury or illness and award notice.

**Fraud Notice**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

**The laws of New York require the following statement appear:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

\_\_\_\_\_  
 Name (Please print or type) Title Email Address

\_\_\_\_\_  
 Signature Date

## Fraud Warning Statements

**The laws of several states require the following statements to appear on the claim form:**

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

**Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**Arkansas, West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Arizona:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**California:** For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Connecticut, Iowa, Nebraska and Oregon:** Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

**Delaware, Indiana and Oklahoma:** WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

**Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

**Kansas:** Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Louisiana and Texas:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

**New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

**Maine, Tennessee and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefit.

**Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**Ohio:** Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Rhode Island:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Vermont:** It is a crime for any person knowingly to provide material false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company, for any person knowingly to provide material false, incomplete, or misleading information concerning the sale of insurance or the status of an insurer, or for any person to misappropriate the funds of an insured or an applicant for insurance. Penalties include imprisonment, fines, and denial of insurance benefits.

**Virginia:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.