GUARDIAN® The Guardian Life Insurance Company of America

Attending Physician's Statement

Send to: Group Long Term Disability Claims, P.O. Box 26025, Lehigh Valley, PA 18002-6025
For Customer Service: (800) 538-4583 Fax: (610) 807-8221 Email: Group_LTD_Claims@GuardianLife.com

EMPLOYEE SECTION

1. Employee Name	2. DOB ____ / ____ / ____	3. Plan #	4. Social Security # - -
5. Address City State Zip			6. Phone # ( )
7. Employer Name			8. Occupation

AUTHORIZATION

9. I authorize any physician, medical practitioner, hospital, clinic, other health facility, consumer reporting agency, the Social Security Administration, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me to The Guardian Life Insurance Company of America or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me. I understand that Guardian will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. Guardian will not release any information obtained to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be lawfully required or permitted, or as I may further authorize. I know that I may request and receive a copy of this authorization. I agree that a photocopy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for the duration of my claim.

"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. In New York the person 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. In California, any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

Signature _____ Date ____ / ____ / ____

PHYSICIAN SECTION

Completion of this form will help to expedite processing of the claim and reduce additional requests and follow up. Your patient is responsible for the cost of completing this form.

1. Diagnosis (including any complications) — ICD9 or DSM IV Codes:

2. Medical evidence that substantiates or contributes to this patient's inability to work (please attach results of x-rays, MRIs, EKGs, etc.)

3. Subjective Complaints

CONDITION HISTORY

4. Patient's symptoms are the result of (check all that apply)
☐ Employment ☐ Pregnancy ☐ Other Accident
☐ Illness ☐ Motor Vehicle Accident ☐ Other _____

5. Date symptoms first appeared or accident occurred ____ / ____ / ____

6. Date of your first evaluation for this condition ____ / ____ / ____

7. Frequency of visit/treatment for this condition
☐ Weekly ☐ Monthly ☐ Other _____

8. Date of most recent visit/treatment for this condition ____ / ____ / ____

9. If inability to work is due to pregnancy, please indicate ☐ expected ☐ actual (check one) delivery date: ____ / ____ / ____
Type of delivery (if applicable) ☐ Vaginal ☐ C-section ☐ Single Birth ☐ Multiple Births

10. Has this patient ever had a similar or related condition? ☐ Yes ☐ No
If "yes", when ____ / ____ / ____ Explain:

11. Was this patient referred to you by another physician? ☐ Yes ☐ No If "Yes", please supply physician's complete name and address, specialty, phone # and fax #:

12. Did you refer this patient to another physician/or provider for treatment of this or a related condition? ☐ Yes ☐ No
If "Yes", please supply the physician's/provider's complete name and address, phone # and fax #:

13. Please supply complete name, address and specialty of any other treating physicians or hospitals including phone # and fax #.

Name	Specialty	Address	Phone #	Fax #	Treatment From	Treatment To
					___ / ___ / ___	___ / ___ / ___
					___ / ___ / ___	___ / ___ / ___
					___ / ___ / ___	___ / ___ / ___

If additional space is needed, please attach a separate sheet

TREATMENT

14. Describe this patient's treatment program: (including any surgeries with date and CPT codes) _____

_____

Medications _____ Counseling _____

Therapies _____ Vocational rehabilitation _____

PROGRESS

15. Patient has ☐ Recovered ☐ Not Changed ☐ Improved ☐ Retrogressed

16. Patient is ☐ Ambulatory ☐ House Confined ☐ Other _____ ☐ Bed Confined ☐ Hospital Confined

17. Did you place the patient on off work status? ☐ Yes ☐ No

18. If yes, what date? ____ / ____ / ____

19. Has patient been released to return to work? ☐ Yes ☐ No

If "Yes", date patient was released to return to work? ____ / ____ / ____

☐ Part Time ☐ Usual Occupation

☐ Full Time ☐ Other Occupation

☐ Other _____

20. If not yet released to return to work, when do you anticipate a release? ____ / ____ / ____ ☐ Part Time ☐ Full Time ☐ Never

21. Physical LIMITATIONS that preclude RETURN TO WORK

- ☐ Class 1 No limitation of functional capacity; capable of heavy work* no restrictions (0-10%)
- ☐ Class 2 Medium manual activity* (15-30%)
- ☐ Class 3 Slight limitation of functional capacity; capable of light work* (35-55%)
- ☐ Class 4 Moderate limitations of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)
- ☐ Class 5 Severe limitations of functional capacity; incapable of minimal (sedentary*) activity (75-100%)

Remarks

*As defined in the Federal Dictionary of Occupational Titles

22. Degree of **mental/nervous impairment** Current GAF **(Global Assessment of Functioning)** _____/90 Please attach mental status exam.

Axis 1 _____ Axis 3 _____

Axis 2 _____ Axis 4 _____

23. Do you believe that this patient is competent to endorse checks and direct the use of the proceeds? ☐ Yes ☐ No

24. Degree of **Cardiac Functional Capacity** (American Heart Association)

☐ Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation)

Please supply patient's: height _____ weight _____ blood pressure _____

PLEASE ATTACH PERTINENT MEDICAL RECORDS INCLUDING BUT NOT LIMITED TO PROGRESS NOTES, DIAGNOSTIC TEST RESULTS, DISCHARGE SUMMARIES, OPERATIVE REPORTS, CONSULTATION REPORTS AND MENTAL STATUS EXAM (IF APPLICABLE). THIS WILL HELP TO EXPEDITE PROCESSING OF CLAIM AND REDUCE ADDITIONAL REQUESTS AND FOLLOW UP.

PHYSICIAN INFORMATION

25. Physician's Name		26. Degree	27. Specialty	
28. Address		29. City	30. State	31. Zip
32. Telephone # ( )	33. Fax # ( )	34. Tax ID #		

35. **Remarks**

FRAUD NOTICE

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes Employee and Attending Physician portions of the form.

_____ Date ____ / ____ / _____

Signature of Physician (no stamp)