GUARDIAN℠ The Guardian Life Insurance Company of America

NRO-315
Group Long Term Disability Claim

Send to the Long Term Disability Claim Office, Box 26025, Lehigh Valley, Pa 18002-6025

EMPLOYEE SECTION	**Notify Guardian when you return to work**		
1. Employee's Name			2. Plan Number **G-**
3. Date of Birth	4. Social Security No.	5. ☐ Male ☐ Female	6. ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated
7. Employee's Address	City	State	Zip
8. Home Telephone #	9. Describe first symptoms of illness or accident		10. Nature of illness or accident
11. Date of accident or first noticed symptoms of illness	12. Was accident or illness related to your employment? ☐ Yes ☐ No If "Yes", have you filed a Worker's Compensation Claim? ☐ Yes ☐ No Do you intend to file a Worker's Compensation Claim? ☐ Yes ☐ No If "No" why not?		
13. Date first treated for this illness or injury	14. Date you become unable to work because of this disability	15. Date you returned to work part time	16. Date you returned to work full-time
17. Date you expect to return to work part time	18. Date you expect to return to work full time	19. If you have engaged in any other work since disability began, explain and give dates	
20. Give your exact job title and explain the duties of your occupation when your disability began.		21. Number of dependent children under age 18 or under age 25 if full-time students	
22. Name and complete address of family physician			
23. Names and complete addresses of physicians and hospitals that first treated you for this illness or injury			
24. Have you ever had the same or similar condition in the past? ☐ Yes ☐ No If "Yes", please give the date of first treatment and provide names and complete addresses of physicians who treated you			
25. Describe any other income you are receiving or are eligible to receive as a result of your disability (e.g., Social Security, Worker's Compensation, state disability, pension, disability/retirement, group disability, no-fault) Source Plan No. Claim No. Amount/How Often Date Claim Filed Date Income Began Date Income Ended			
26. If your request for Long Term Disability benefits is approved, amount you want us to withhold from each payment for federal income tax (must be whole dollar amount of at least $20 and may not reduce payment to less than $10) _____ _____ Signature of Employee Date			$ (Or %)

27. I authorize any physician, medical practitioner, hospital, clinic, other health facility, consumer reporting agencies, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information about me in its possession 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 my medical history, mental or physical condition, or treatment. 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 of Employee Date

EMPLOYER SECTION	**Send the Attending Physician's Statement (Form NRO 117), the employee's job description, and award or denial letter for other income benefits with this form.**

1. Planholder/Employer Name				2. Plan Number **G-**
3. Planholder/Employer Address: City State Zip				4. Telephone Number
5. If branch or affiliate, name & relationship to parent company			6. Employer Social Security or Tax I.D. Number	
7. Employee's Name	8. Date of Birth	9. Date of Employment	10. Certificate No.	11. Insurance Class
12. Date insurance effective under this plan	13. Job Title at time last worked	14. Schedule at time last worked _____ hrs per day, _____ days per week		15. Date disability began
16. Date last worked	17. Reason for leaving work ☐ dismissed ☐ leave of absence ☐ disability ☐ resigned ☐ retired ☐ layoff		18. Date terminated for disability	19. Last full day of disability
20. Has the employee returned to work? ☐ Yes ☐ No If "Yes", ☐ Part Time ☐ Full Time Is the employee presently performing all duties performed prior to disability ☐ Yes ☐ No				
21. Average earnings excluding bonus, overtime, and special compensation on the redetermination date of you plan $ ☐ Week ☐ Month ☐ Year	22. Employee is paid ☐ hourly ☐ by partnership ☐ salary ☐ commissions only ☐ salary & commissions ☐ salary & bonus			23. If employee contributes to cost of this insurance ____% paid by employee ____% paid by employer
24. Is employee eligible for salary continuation? ☐ Yes ☐ No If "Yes", is it a benefit provided by a group plan? ☐ Yes ☐ No				
25. Dates eligible for salary continuation begins _____ ends _____	26. Amount of Salary Continuation $ _____ ☐ Week ☐ Month	27. Is employee eligible for worker's compensation? ☐ Yes ☐ No		28. Amount of worker's compensation Weekly $ _____ Date comp. began _____
29. If employee is eligible, give worker's compensation plan number _____ and name and address of carrier				
30. If employee is eligible for pension, is it ☐ Disability ☐ Retirement ☐ _____?			31. If employee contributes to pension, percent attributed to employee contribution _____%	
32. Date employee was eligible under pension	33. Pension benefits paid ☐ Monthly ☐ Annually ☐ Lump Sum ☐ _____		34. Benefit begins	35. Benefit ends
36. Name, type, & complete address of pension fund				

Federal law requires a third-party payer, such as an insurance company, to withhold income taxes from sick pay payments if the employee so requests. Sick pay includes Short Term (Weekly Loss of Time) and Long Term Disability benefits provided under an employer-sponsored group insurance plan as well as statutory disability benefits.

An employee who elects to have federal income taxes withheld from disability benefit payments must provide the information requested in Question No. 26 in the Employee Section. We will withhold the requested amount until the employee notifies us in writing to modify or terminate the request.

If coverage is provided to employees under the terms of a collective bargaining agreement, an employee need not request withholding provided that the agreement specifies that IRC section 3402(0)(5), the sick pay withholding provision, will apply to sick pay paid pursuant to the agreement and provided also that the agreement states the manner in which the amount withheld is to be determined. Notify Guardian how much income tax to withhold and provide the Social Security Number of the employee from whom we are to withhold taxes.

The law also requires us to give you a written report by January 15 of the year succeeding that in which disability payments were made. Our report will give the name of each employee who received disability payments, the total amount of benefits paid, and the total amount of income tax withheld from each employee's payments. If taxes were withheld from an employee's disability payments, we must also give you the employee's social security number.

By January 31, you must provide a W-2 statement to each employee who has received disability payments. The W-2 must contain all the information you received from us and must show which portion, if any, of the employee's disability payments is excludable from gross pay and which is not. Contact your tax consultant if you have any questions about sick pay withholding.

37. Remarks

38. I agree to notify Guardian when the employee receives a benefit from the pension fund and when the employee is no longer required to contribute to it. I certify that I have reviewed the employee section and that the employee named above has been a full-time, active employee for whom premiums have been paid.

_____ _____

Signature and Title Date