PACIFIC GUARDIAN LIFE

Group Long Term Disability Claim

Notice of Claim

Employer → **Employee** → **Doctor** → **Insurance Company**

Employer Instructions

At approximately 30 days before end of elimination period:

A. Complete the Employer's Report of Claim form in full and transmit this portion only to the address below.

Include

- Job description (detailed duties)
- Copy of enrollment card (if employee contributes to premium)
- Copy of approved medical evidence of insurability if required at time of enrollment
- Documentation of earnings if other than straight salary
- If Workers' Compensation claim filed, include copy of First Report of Accident and the decision

B. Give remaining two-part form to claimant for completion.

Request

- Birth certificate (short duration claim and under age 50 not necessary at this time)
- Copy of awards from other source of benefits: Social Security, Workers' Compensation, retirement, state disability, others

C. If claimant has more than one treating physician, give claimant additional forms for completion.

D. All portion of this form package must be completed to avoid undue delay in processing claimants' request for benefits.

For your protection California laws and the laws of some states require the following to appear on this form: Any person who knowingly presents 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.

RESET

EMPLOYER'S REPORT OF CLAIM- To be completed by employer

Claimant

1. Employee's Full Name:	2. Social Security Number:	3. Date of Birth:

4. Street Address: City: State: Zip:

Employment

5. Insurance Class:	6. Employee Date of Hire:	7. Date employee became insured for LTD:	8. Date employee was actually last present at work:

9. Occupation at time last worked (attach job description):

10. Work schedule at time last worked:
No. of days per week: No. of hours per day:

11. Reason for stopping:
❑ Sickness ❑ Resigned ❑ Dismissed ❑ Laid off
❑ Retired ❑ Granted LOA ❑ Vacation ❑ Other

12. Has employee returned to work? ❑ Yes ❑ No
❑ Part-time Date: ❑ Full-time Date:

Income

13. How is employee paid?
❑ Straight Salary ❑ Hourly
❑ Salary & Commissions ❑ Salary & Bonus
❑ Commissions Only

14. Employee's Basic **Monthly** Earnings:
If salary is based on less than
$ LTD Benefit: 12 months, number of months:

15. Employee's percentage of LTD premium contribution. Employee pays: Employer pays:

OTHER BENEFITS

16. Has insured received other disability payments since time last worked?

Salary Continuance:	Insured Short Term:	Other Type: _____
❑ Yes Weekly Amount: _____	❑ Yes Weekly Amount: _____	❑ Yes Weekly Amount: _____
Date benefits cease: _____	Date benefits cease: _____	Date benefits cease: _____
❑ No	❑ No	❑ No

17. Did claim result from job activity?
❑ Yes (Explain) _____
❑ No _____
_____

18. Has workers' compensation claim been filed? (Enclose copy)
❑ Yes
❑ Pending
❑ Denied

19. Workers' compensation weekly amount:
(Include copy of the first report of accident.)
$

RETIREMENT

20. Is employee covered by employer-sponsored retirement plan?
❑ Yes ❑ No

21. Does retirement plan contain a disability provision?
❑ Yes ❑ No

22. Is employee or will this employee be eligible for a disability or retirement pension? Monthly Amount $ _____ (Enclose copy of summary plan description)
❑ Yes If "Yes" type: _____ ❑ Disability ❑ Retirement
❑ No ❑ Other: Commencement Date of Benefits:

Note: If any portion of this pension benefit is attributable to the employee's contribution, please provide details including the the percentage of his/her contribution to the total contribution.

Certification

23. Employer's Name (of indicate association and name of policyholder, if other):	24. Telephone Number:	25. Group Policy Number:

26. Street Address: City: State: Zip:

27. Employer (Taxpayer) I.D. Number (EIN) OR Public Employer Social Security No. 69:

28. Name of person completing this form (please type or print):

29. Signature of Authorized Insurance Representatives: Title: Date:

Send this form (with enclosures) to: Pacific Guardian Life, Group Claims Department, P.O. Box 14294, Lexington, KY 40512-4294 or Fax to (855) 864-0530.
Give the remaining forms to claimant for completion.

PACIFIC GUARDIAN LIFE

Group Long Term Disability

Application for LTD Benefits

Employee → **Doctor** → **Insurance Company**

Employee Instructions

A. Complete and sign the Employee's Authorization For Release of Information form.
This will allow our insurance carrier or their representative to secure additional information (if necessary) to make a decision on your request for benefit payments.

B. Complete Employee's Disability Benefits Application in full.

Attach
- Copy of your Birth Certificate if disability is indefinite.
- Copy of Social Security and other income entitlement awards (or forward when received)

C. Give the Employee's Authorization For Release of Information form and attached Employee's Disability Benefits Application to the physician treating you (if more than one, obtain other forms for completion from employer). Instruct your attending physician to send his statement along with yours to the insurance carrier.

D. When those forms are received by the insurance company, they will advise you of your eligibility for the benefits or of any additional information that may be needed.

For your protection California laws and the laws of some states require the following to appear on this form: Any person who knowingly presents 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.

EMPLOYEE'S AUTHORIZATION FOR RELEASE OF INFORMATION -To be completed by employee

Authorization

Policy No.:

To Whom It May Concern:

I,_____ hereby authorize any hospital, physician, medical practitioner, clinic, other
(Claimant's Name)
medical or medically related facility, pharmacy, insurance company or Government Agency to disclose or furnish to Pacific Guradian Life Insurance Company, Ltd., its subsidiaries or representatives, any and all information with respect to any illness including mental illness, drug/acohol abuse, injury, medical history, consultations, prescriptions, treatments or benefits, and copies of all applicable records that may be requested. I also authorize my employer to disclose all information needed to process my claim.

The information provided to Pacific Guardian Life Insurance Company, Ltd., its subsidaries or representatives is to be used solely for the administration of claim(s) as captioned above. A photostatic of this Authorization is to be considered as valid as the original and is effective for the duration of the claim.

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil pernalties.

Date

Patient's (Claimant's) Signature

Relationship of Authorized Person, if other

Authorized Person's Signature

Give this authorization to the physician treating you.

Note: A true copy of this Authorization is available to the patient or his authorized representative at any time, upon request.

EMPLOYEE'S DISABILITY BENEFITS APPLICATION- To be completed by employee

Claimant

1. Employee's Full Name:	2. Social Security Number:	3. Phone No.:

4. Street Address: City: State: Zip:

5. Date of Birth:	6. Height:	7. Weight:	8. Sex: ❑ Male ❑ Female	9. Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

10. Spouse's First Name:	11. Spouse's Date of Birth:	12. Is spouse employed? ❑ Yes ❑ No	13. Number of children under age 19:

14. List names and birth dates of unmarried children who have not finished high school.

Employment

15. Employer's Name:	16. Group Policy No:

17. Occupation (List duties of occupation at time of disability):

18. Date of accident or date first noticed symptoms of illness:	19. Date unable to work because of disability:	20. Date returned to work on a part-time basis:	21. Date returned to work on a full-time basis:

22. Is your accident or illness related to your occupation? ❑ Yes ❑ No

If "Yes" Explain:

23. Have you or do you intend to file Workers' Compensation claim? ❑ Yes ❑ No

Claim History

24. Describe how and where accident occurred or the onset and nature of your illness:

25. Date first treated for your illness or injury:	28. Did you have the same or a similar condition in the past: If "Yes", complete Numbers 29-30. ❑ Yes ❑ No
26. Name and Address of Hospital Treated by:	29. Name and Address of Hospital Treated by:
27. Name and Address of Physician Treated by:	30. Name and Address of Physician Treated by:

Income

31. Describe other income you are receiving.

Type	Yes	No	Amount	Date Began	Date Ended
Social Security (disability/retirement)	❑	❑	$		
State Disability	❑	❑	$		
Retirement (normal/early/disability)	❑	❑	$		
Workers' Compensation	❑	❑	$		
Group Disability Benefits	❑	❑	$		
Other (Specify)	❑	❑			

Benefit

32. Did you or do you plan to apply for benefit described above? ❑ Yes ❑ No

Type: Date application filed: Type: Date application filed:

33. If your request for benefits is approved, do you want amounts withheld from each check for Federal Income Tax purposes? ❑ Yes ❑ No

34. If "Yes," indicate amount per week: ($20.00 minimum) $ Signature:

The above statements are true and complete to the best of my knowledge and belief.

Employee's Signature: Date:

Give this application to the physician treating you.

ATTENDING PHYSICIAN'S STATEMENT **Return to: Pacific Guardian Life, P.O. Box 14294, Lexington, KY 40512-4294 or Fax to (855) 864-0530.**

History

1. Patient's Full Name: | 2. Date of Birth:

3. Date symptoms first appeared or accident happened: | 4. Date patient ceased work because of disability: | 5. Is condition due to injury or sickness arising out of patient's employment ❑ Yes ❑ No ❑ Unknown

6. Has patient ever had same or similar condition? ❑ Yes ❑ No If "Yes", state when and describe:

7. Names and addresses of other treating physicians:

Diagnosis

8. Diagnosis (including complications):

9. If pregnancy, estimated date of delivery: | 10. Subjective symptoms:

11. Objective Findings (including current x-rays, EKG's, laboratory data and any clinical findings):

Treatment

12. Date of first visit: | 13. Date of last visit: | 14. Frequency: ❑Weekly ❑Monthly ❑ Other (specify):

15. Nature of treatment (including surgery and medications prescribed, if any):

Progress

16. Is patient: ❑ Recovered ❑ Retrogressed ❑ Improve ❑ Unchanged | 17. Is patient: ❑ Ambulatory ❑ House confined ❑ Bed confined ❑ Hospital confined | 18. Has patient been hospital confined? ❑Yes ❑ No Confined from: through:

19. If Hospital confined, give name and address of hospital:

Cardiac

20. Functional capacity (American Heart Association):
❑ Class1 (No limitation) ❑ Class 2 (Slight limation) ❑ Class 3 (Marked limitation) ❑ Class 4 (Complete limitation)

21. Blood Pressure (last visit):
Systolic/ Diastolic:

Impairments

22. Physical Impairments(*As defined in Federal Dictionary of Occupational Titles)

- ❑ 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 limitation of functional capacity capable of clerical/administrative (sedentary*) activity……..……..(60- 70%)
- ❑ Class 5-Severe limitation of functional capacity incapable of minimal (sedentary*) activity…… (75-100%)

Remarks:

23. Mental Impairments (if applicable)

Define "stress" as it applies to this claimant:

What stress and problems in interpersonal relations has claimant had on job?

- ❑ Class 1-Patient is able to function under stress and engage in interpersonal relations (no limitations).
- ❑ Class 2-Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations).
- ❑ Class 3- Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations).
- ❑ Class 4-Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations). clerical/administrative (sedentary*) activity……..……..……..…
- ❑ Class 5-Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations).

Prognosis

24. Is patient now totally disabled?
Patient's job: ❑ Yes ❑ No
Other work? ❑ Yes ❑ No

25. Date patient became disabled due to present illness:

26. When can a fundamental or marked change be expected?
❑ 1 Mo. ❑ 1-3 Mos. ❑ 3-6 Mos. ❑ Never
Applies to: ❑ Patient's job ❑ Other work

Rehabilitation

27. Is patient a suitable candidate for occupational rehabilitation?
Patient's job: ❑ Yes ❑ No
Other work? ❑ Yes ❑ No

28. Can present job be modified to allow for impairment?
❑ Yes ❑ No

29. When could trial employment commerce?
Patient's job: ❑ Full-time ❑ Part-time
Other work? ❑ Full-time ❑ Part-time

Remarks (Limitations, Therapy, etc.):

Name (Attending Physician)- Please Print: Degree: Telephone:

Street Address: City: State: Zipcode:

Signature: Date: