GUARDIAN℠ The Guardian Life Insurance Company of America

NRO-117

Attending Physician's Statement of Disability

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

EMPLOYEE SECTION

1. Employee Name	2. DOB ____ / ____ / ____	3. Plan Number	4. Social Security Number - -
5. Address City State Zip			6. Phone Number ( )
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

Your patient is responsible for the cost of completing this form

1. Diagnosis (including any complications)

2. Objective findings which substantiate or contribute to this patient's disability (please supply results of x-rays, MRIs, EKGs, etc.)

3. Subjective Symptoms

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 you feel this patient was first unable to work ____ / ____ / ____	7. Date of first visit for this condition ____ / ____ / ____
8. Frequency of treatment ☐ Weekly ☐ Monthly ☐ Other ____________	9. Date of most recent visit/treatment for this condition ____ / ____ / ____	10. Date of last comprehensive examination ____ / ____ / ____

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

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

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

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

15) Please supply complete names and addresses of any other treating physicians or hospitals

Name	City	State	ZIP	Treatment From	Treatment To
				____ / ____ / ____	____ / ____ / ____
				____ / ____ / ____	____ / ____ / ____
				____ / ____ / ____	____ / ____ / ____
				____ / ____ / ____	____ / ____ / ____

(6/00)

TREATMENT

16. Describe this patient's treatment program (including any surgeries, medications or therapies)

PROGRESS

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

18. Patient is ☐ Ambulatory ☐ House Confined ☐ Other __________________ ☐ Bed Confined ☐ Hospital Confined

LIMITATIONS

19. Is patient totally disabled for his/her usual occupation? ☐ Yes ☐ No

20. Is patient totally disabled for any occupation? ☐ Yes ☐ No

21. If not totally disabled for usual or any occupation, 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 ____

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

23. Degree of **physical impairment**

☐ 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

Please supply patient's height _____ feet _____ inches and weight _______ lbs.

*as defined in the Federal Dictionary of Occupational Titles

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)

Blood pressure at last visit Systolic __________ Diastolic __________

25. Define stress as it applies to this patient's occupation and day to day life

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

27. Degree of **mental/nervous impairment** Current GAF (Global Assessment of Functioning) _______/90

☐ Class 1 Patient is able to function under stress and engage in interpersonal relationships (no limitations)
☐ Class 2 Patient is able to function in most stress situations and engage in most interpersonal relationships (slight limitations)
☐ Class 3 Patient is able to engage in only limited stress situations and engage in only limited interpersonal relationships (moderate limitations)
☐ Class 4 Patient is unable to engage in stress situations or engage in interpersonal relationships (marked limitations)
☐ Class 5 Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks:

REHABILITATION

28. Is the patient a suitable candidate for ☐ Work Hardening ☐ Cardiac Rehabilitation ☐ Other ______________________________ ☐ Vocational Rehabilitation ☐ Physical Therapy ☐ None of these

29. What modifications do you feel could be made to this patient's job to enable him/her to return to work?

REMARKS

30.

PHYSICIAN INFORMATION

31. Physician's Name		32. Degree	33. Specialty	
34. Address		35. City	36. State	37. Zip
38. Telephone ( )	39. Fax ( )	40. Tax ID		

Signature ____ Date ____ / ____ / _____