



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 <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> 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				Treatment	
Name	City	State	ZIP	From	To
_____	_____	_____	_____	____/____/____	____/____/____
_____	_____	_____	_____	____/____/____	____/____/____
_____	_____	_____	_____	____/____/____	____/____/____
_____	_____	_____	_____	____/____/____	____/____/____

TREATMENT			
16. Describe this patient's treatment program (including any surgeries, medications or therapies)			
PROGRESS			
17. Patient has <input type="checkbox"/> Recovered <input type="checkbox"/> Not Changed <input type="checkbox"/> Improved <input type="checkbox"/> Retrogressed		18. Patient is <input type="checkbox"/> Ambulatory <input type="checkbox"/> House Confined <input type="checkbox"/> Other _____ <input type="checkbox"/> Bed Confined <input type="checkbox"/> Hospital Confined	
LIMITATIONS			
19. Is patient totally disabled for his/her usual occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No		20. Is patient totally disabled for any occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
21. If not totally disabled for usual or any occupation, has patient been released to return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes", date patient was released to return to work? ____ / ____ / ____		<input type="checkbox"/> Part Time <input type="checkbox"/> Usual Occupation <input type="checkbox"/> Full Time <input type="checkbox"/> Other Occupation <input type="checkbox"/> Other _____	
22. If not yet released to return to work, when do you anticipate a release? ____ / ____ / ____ <input type="checkbox"/> Part Time <input type="checkbox"/> Full Time <input type="checkbox"/> Never			
23. Degree of physical impairment			
<input type="checkbox"/> Class 1 No limitation of functional capacity; capable of heavy work* no restrictions (0-10%)			
<input type="checkbox"/> Class 2 Medium manual activity* (15-30%)			
<input type="checkbox"/> Class 3 Slight limitation of functional capacity; capable of light work* (35-55%)			
<input type="checkbox"/> Class 4 Moderate limitations of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)			
<input type="checkbox"/> 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)			
<input type="checkbox"/> Class 1 (No Limitation) <input type="checkbox"/> Class 2 (Slight Limitation) <input type="checkbox"/> Class 3 (Marked Limitation) <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
27. Degree of mental/nervous impairment Current GAF (Global Assessment of Functioning) ____/90			
<input type="checkbox"/> Class 1 Patient is able to function under stress and engage in interpersonal relationships (no limitations)			
<input type="checkbox"/> Class 2 Patient is able to function in most stress situations and engage in most interpersonal relationships (slight limitations)			
<input type="checkbox"/> Class 3 Patient is able to engage in only limited stress situations and engage in only limited interpersonal relationships (moderate limitations)			
<input type="checkbox"/> Class 4 Patient is unable to engage in stress situations or engage in interpersonal relationships (marked limitations)			
<input type="checkbox"/> 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 <input type="checkbox"/> Work Hardening <input type="checkbox"/> Cardiac Rehabilitation <input type="checkbox"/> Other _____ <input type="checkbox"/> Vocational Rehabilitation <input type="checkbox"/> Physical Therapy <input type="checkbox"/> 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 ____ / ____ / ____	