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APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS

This application package is divided into four sections, as follows:

- Section I** **Employer's Statement** - to be completed by the **employer's** authorized representative.

- Section II** **Employee's Statement** - to be completed by the **employee** who is applying for Short Term Disability Benefits.

- Section III** **Authorization to Obtain Information** - to be signed by the **employee**.

- Section IV** **Attending Physician's Statement** - to be completed by the physician who is treating the **employee**.

Please return claim form and documentation to:

AlwaysCare Benefits
P.O. Box 2993
Hartford, CT 06104-2993
Telephone Number: 1-866-561-2690
Fax Number: (860) 843-4716

PLEASE SEE THAT ALL SECTIONS ARE FULLY COMPLETED AND SIGNED. FORWARD THE COMPLETED APPLICATION TO YOUR ALWAYS CARE BENEFITS MANAGEMENT SERVICE CENTER.



APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS

To Be Completed by the Employer

Section I - Employer's Section

This claim is for (Employee's Name)	Social Security Number	Date of Birth
Employee's Address (Street, City, State, Zip)		

A. Information About the Employer

Company's Name	Group Policy Number
Address (Street, City, State, Zip)	
Name and Address of Division Where Employee Works (if different from above)	

B. Information About the Employee

Date employee was hired:	What was the employee's regularly scheduled work week? Hours per Week _____ Scheduled workdays M - F _____
Date employee became insured under this plan:	Other: _____
Is Employee Enrolled in AlwaysCare's Long Term Disability Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Effective Date _____	
Was the employee's STD insurance issued on the basis of a Personal Health Statement? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes, attach copy.	
Was the employee insured under your prior STD policy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide the inclusive date of coverage. From _____ Through _____	
Was the employee on Qualified Family Leave when disability began? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did STD & LTD insurance continue while on Family Leave? <input type="checkbox"/> Yes <input type="checkbox"/> No Date Leave of Absence started under Family Leave Act: _____	

C. Information Needed for Withholding and Reporting Taxes

What % of this employee's STD benefit is taxable? ____%. What percentage, if any, do you contribute towards the cost of the STD premium? ____%. Does the employee contribute towards the cost of the STD premium? Yes No. If "Yes," at what %? ____%. Is it on a Pre or Post-tax basis? What % of this employee's LTD benefits is taxable? ____%. Does the employee contribute towards the cost of the LTD premium? Yes No. If "Yes," at what %? ____%. Is it on a Pre or Post-tax basis?

D. Information About the Claim

What was the employee's permanent job on his or her last day at work? (Please attach a copy of the employee's job description.)	
Last day employee actually worked?	On that day, did the employee work a full day? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," how many hours were worked? _____
Why did employee stop working?	Is the employee's condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has a claim been filed with Workers' Compensation? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," send initial report of illness or injury or award notice.	Date employee is expected to return to work? _____ Full time? <input type="checkbox"/> Yes <input type="checkbox"/> No

E. Information About Salary

Employee's weekly/hourly rate of pay \$ _____

Will/Is Employee receive(ing) Workers' Compensation Payments? Yes No

Weekly Amount \$ _____ Date Payments Started _____ Date Payments Will End _____

Is employee receiving Salary Continuance or Sick Leave? Yes No

Weekly Amount \$ _____ Date Payments Started _____ Date Payments Will End _____

F. Information About the Physical Aspects of the Employee's Job

Check the items below that relate to the employee's job and complete the information requested. Use these definitions for the frequency of occurrence:

- Not Applicable** means the person does not perform this activity.
- Occasionally** means the person does the activity up to 33% of the time.
- Frequently** means the person does the activity 34% to 66% of the time.
- Continuously** means the person does the activity 67% to 100% of the time.

Activity	Frequency of Occurrence			
	N/A	Occasionally	Frequently	Continuously
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Balancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crouching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crawling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Reaching/working overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Keyboard Use/Repetitive Hand Motion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activity	Description	Frequency	Weight
<input type="checkbox"/> Pushing	_____	_____	_____ lbs.
<input type="checkbox"/> Pulling	_____	_____	_____ lbs.
<input type="checkbox"/> Lifting	_____	_____	_____ lbs.
<input type="checkbox"/> Carrying	_____	_____	_____ lbs.

Can the job be performed by alternating sitting and standing? Yes No

What are the major tasks requiring the use of one or both hands? Indicate the percentage of the employee's workday that is spent on each of these tasks.

_____ %

_____ %

_____ %

G. Information About the Job as it Relates to the Disability

Can the job be modified to accommodate the disability either temporarily or permanently? Yes No If "Yes," explain.

Is it possible to offer the employee assistance in doing the job (e.g., through the use of technology or personal assistance)? Yes No If "Yes," explain.

H. Signature

Name (Please print or type)

Signature

() _____
Area Code Telephone Number

Title

Date

() _____
Area Code Fax Number



APPLICATION FOR SHORT TERM DISABILITY INCOME BENEFITS

To Be Completed by the Employee (BE SURE TO ANSWER ALL QUESTIONS - FAILURE TO DO SO MAY DELAY YOUR CLAIM)

Section II - Employee's Section

A. Information About You

Form A: Information About You. Fields include Last Name (First, Middle Initial), Social Security Number, Address, Telephone Number (Area Code), Date of Birth, Gender (Male/Female), Marital Status (Single/Married/Widowed/Divorced), and Your Employer.

B. For an Injury, answer the following questions

Form B: For an Injury. Question: When (i.e., date/time), where and how did the injury occur?

C. For Illness, Injury or Pregnancy, answer the following questions

Form C: For Illness, Injury or Pregnancy. Fields include Date you were first treated by a physician, Name of Physician, Address of Physician, Telephone Number, and several yes/no questions regarding job changes, work inability, insurance, and workers' compensation claims.

D. Information About the Disability

Form D: Information About the Disability. Fields include Last day you worked before the disability, Did you work a full day?, Date you were first unable to work, and questions about work done since the disability date.

E. Information About Tax Withholding

Form E: Information About Tax Withholding. Text explaining federal law requirements for tax withholding and instructions for indicating the amount to be withheld.

F. Signature

With the exception of any source(s) of income reported above in Section D of this form, I certify by my signature that I have not received and am not eligible to receive any source of income, except for my Disability Income. Further, I understand that should I receive income of any kind or perform work of any kind during any period that has been approved for my disability claim, I must report all details to AlwaysCare immediately.

If I receive disability benefits greater than those which should have been paid, I understand that I will be required to provide a lump sum repayment to AlwaysCare. The insurance company has the option to reduce or eliminate future disability payments in order to recover any overpayment balance that is not reimbursed.

For residents of all states EXCEPT California, Florida, New Jersey, Colorado, Pennsylvania, Arkansas, New Mexico, Louisiana, New York, Virginia and Puerto Rico: A person commits a fraudulent insurance act if that person knowingly, and with intent to defraud any insurance company or other person, either: (a) files an application for insurance or statement of claim containing any materially false information, or (b) conceals information concerning any material fact in order to obtain an insurance policy or a benefit under an insurance policy. **A fraudulent insurance act is a crime.** (In Oregon, a fraudulent insurance act may be a crime.) The company shall pursue prosecution of any fraudulent insurance act to the fullest extent of the law.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

For residents of New Jersey, Arkansas, and New Mexico: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of Pennsylvania: 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 and subjects a person to criminal and civil penalties.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading information to an Insurance Company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or its agent who knowingly provides false, incomplete, or misleading information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to an insurance settlement or award shall be reported to the Colorado Division of Insurance.

FOR RESIDENTS OF CALIFORNIA: FOR YOUR PROTECTION, CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: "ANY PERSON WHO KNOWINGLY PRESENTS A 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."

For residents of Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New York: 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, and 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.

For residents of Puerto Rico: Any person who knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

For residents of Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

The statements contained in this form are true and complete to the best of my knowledge and belief.

X _____
Signature of the Employee

X _____
Date

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Section III

To: Any health care provider, employer, benefit plan, insurer, financial institution, consumer reporting agency, educational institution, or Federal, State, or Local Government Agency, including the Social Security Administration and Veterans Administration. I authorize you to disclose to AlwaysCare a complete copy of any and all of the following personal or privileged information, records or documents relative to:

Insured's Name (*Please print*)

(Date of Birth)

(Last 5 Digits of SSN)

Any and all medical information or records, including x-ray films, medical histories, physical, mental or diagnostic examinations, and treatment notes, and including information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may be related to my claim for benefits; work information and history, including job duties, earnings and personnel records, and client lists; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims; credit information, including credit reports and credit applications; other financial information, including pension benefits, bank records; business transactions billing, invoices, and payment records; academic transcripts; and information concerning Social Security benefits, including, monthly benefit amounts, monthly payment amounts, entitlement dates, and information from my Master Beneficiary Record. The information obtained by use of this Authorization will be used for the purpose of evaluating and administering my claim for benefits under my employer's benefit plan. Such information shall be referred to herein collectively as "My Information." I understand I have the right to revoke this Authorization for future disclosures, except to the extent action has been taken in reliance upon this Authorization. I must revoke this Authorization in writing directly to AlwaysCare.

I ALSO UNDERSTAND that once My Information has been disclosed to AlwaysCare, as permitted under this Authorization, it may be re-disclosed by AlwaysCare as permitted by law or my further authorization. I authorize AlwaysCare to use or disclose My Information (i) to my employer for a) functions related to accommodating my disability; b) responding to claims related to accommodation or adverse or discriminatory treatment related to my claim; c) responding to any litigation or agency charge document production request or lawful subpoena; d) federal or state Family & Medical Leave Act administration; or e) fulfilling fiduciary obligations under my benefit plan; (ii) to the administrator or other service providers of my employer's benefit plan or other benefit plans of my employer for plan-related functions; (iii) to any claim system used for claims processing or insurance broker to carry out functions related to my benefit plan or claim; (iv) to any health care professional who has treated or evaluated me or who may do so; (v) to other persons or entities performing business or legal services related my claim; (vi) as may be lawfully required; or (vii) as may be necessary to prevent or detect perpetration of a fraud.

I understand that information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient. I understand that I have the right to revoke this Authorization for future disclosures AlwaysCare may make unless AlwaysCare has taken action in reliance upon this Authorization. I must revoke this Authorization in writing directly to AlwaysCare. I understand that my medical treatment or payment for medical benefits cannot be conditioned on my allowing AlwaysCare to re-disclose My Information. The authorizations set forth herein expire two years from the date listed below, or upon my revocation, if earlier, but will not exceed the term of my coverage under the policy or benefit plan, except as may be necessary to prevent or detect perpetration of a fraud. I understand that I am entitled to receive a copy of this Authorization upon request. A photocopy or facsimile of this Authorization shall be as valid as the original. If there is a conflict between a prior request for restriction on the disclosure of My Information and this Authorization, this Authorization will control.

Signature of Insured or Guardian

Relationship to Insured (*if signed by Guardian*)

Date

HISTORY

Patient's Name _____ Social Security Number _____ Date of Birth _____
 Patient's condition is the result of Illness Injury Pregnancy Mental/Nervous Condition
 If pregnancy, what is the expected date of delivery? Month _____ Day _____ Year _____ LMP Date _____
 Is condition due to an illness or an injury that is work related? Yes No Height _____ Weight _____

DIAGNOSIS

Diagnosis (including any complications) _____
 CD9 Codes _____
 Subjective Symptoms _____
 Physical Findings (list all test results, or enclose test)
 Test _____ Date _____ Results _____
 Test _____ Date _____ Results _____
 Blood Pressure (Systolic) _____ (Diastolic) _____ (Date) _____
 Remarks: _____

TREATMENT

Date of onset of this condition? _____ List all dates of treatment for this condition since patient ceased work: _____
 Date of next office visit _____
 Has patient been referred to any other physician? Yes No If "Yes," Date(s) _____
 Name and address _____ Specialty _____
 Nature of treatment for this condition (including surgery/medications) _____
 Was patient hospitalized for this condition? Yes No If "Yes," Date(s) admitted _____
 Date(s) discharged _____ Name and Address of Hospital(s) _____
 Was surgery performed? Yes No If "Yes," Date _____ Procedure _____ CPT Code _____
 Progress (please check one) Recovered Improved Unchanged Retrogressed

IMPAIRMENT

What are the patient's current physical limitations and restrictions?
 No limitation of functional capacity; capable of heavy work, no restrictions.
 (Lifting 100 lbs. maximum with frequent lifting and/or carrying objects weighing up to 50 lbs.)
 Medium manual activity.
 (Lifting 50 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 25 lbs.)
 Slight limitation of functional capacity; capable of light work.
 (Lifting 20 lbs. maximum with frequent lifting and/or carrying of objects weighing up to 10 lbs. Even though the weight lifted may be only a negligible amount, a job is in this category when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls, or when it requires walking or standing to a significant degree.)
 Moderate limitation of functional capacity; capable of clerical/administrative (sedentary) activity.
 (Lifting 10 lbs. maximum and occasionally lifting and/or carrying articles. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties.)
 Severe limitation of functional capacity; incapable of minimal (sedentary) activity.

What is the psychiatric impairment (if applicable)?
 Inadequate information to make assessment.
 Essentially good functioning in all areas. Occupationally and socially effective.
 Slight difficulty in occupational functioning, but generally functioning well. Has some meaningful interpersonal relationships.
 Moderate impairment in occupational functioning. Limited in performing some occupational duties.
 Major impairment in several areas--work, family relations. Avoidant behavior, neglects family, is unable to work.
 Inability to function in almost all areas.

Date patient ceased work due to this impairment: _____
 (Month, Day, Year)
 If physical or psychiatric limitations exist, indicate the date limitations lasted, or will last through: _____
 (Month, Day, Year)

Attending Physician's Name _____ Tel #: () _____ Fax # () _____
 SS# or E.I.N. # _____ Degree _____ Specialty _____
 Street Address _____ City _____ State _____ Zip Code _____
 Signature _____ Date Signed _____