NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

State Disability Claims
P.O. Box
/ H [L Q J W R Q . <
Telephone#18002682525
Fax# 6108072953

CLAIMANT: READ THE FOLLOWING INSTRUCTIONS CAREFULLY BEFORE COMPLETING THIS CLAIM FORM

After Parts A, B, & C are completed, Mail to: Guardian Disability Claims P.O. Box 981578, El Paso, TX 79998 Fax: 610-807-2953
Documents can be returned electronically at www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.

NOTICE OF PROOF OF CLAIM FOR DISABILITY BENEFITS: IMPORTANT: Use this form only when the claimant becomes sick or d employed or becomes sick or disabled within four (4) weeks after termination of employment. Otherwise use the Group claim

Part B – Health Care Provider's Statement (Please Print or Type): The Health Care Provider's Statement must be completed and the Form to the insurance Carrier or Self-Insured employer, or returned to the claimant within SEVEN DAYS of the receipt of the Form. For item 7c, approxim date. Make some estimate. If the Disability was caused by or aggravated in connection with pregnancy, enter the estimated delivery date under "Re

1. Claimant's Name: (First, Middle, Last)	2. Date of Birth	3. Sex ☐ Male ☐ Female
4. Diagnosis/Analysis: _____ ICD _____		
a. Claimant's Symptoms: _____		
b. Objective Findings/Treatment Plan: _____		
c. If Disability is pregnancy related, enter DELIVERY DATE _____ ☐ Estimated ☐ Actual ☐ Vaginal ☐ C-Section		
5. Claimant Hospitalized? ☐ YES ☐ NO	Date From _____ To _____	
6. Operation Indicated? ☐ YES ☐ NO	a. Type _____ b. Date _____ c. CPT _____	

7. Enter Dates for the Following:
   a. Date of your first treatment for this disability _
   b. Date of your most recent treatment for this disability _ _ _ _ _ _ _ _ _ _ _ _
   c. Date Claimant was

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