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

After Parts A, B, & C are completed, Mail to: Guardian – State Disability Claims – P.O. Box 981578, El Paso, TX 79998-1578 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 DB-300, green clain
Part B – Health Care Provider's Statement (Please Print or Type). The Health Care Provider's Statement must be completely and the Form mailed to the insurance Carrier or Self Insured employer, or return to the claimant within SEVEN DAYS of the receipt of the Form. For items 7c and 7d, approxim date. Make some estimate. If the Disability was caused by or arose in connection with pregnancy, enter the estimated delivery date under "Rer

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 unable to work for this disability _ _ _ _ di_ EMC /Span(_ _)0.55(aie)-6.00164.36 Claimant_as EMC Q .02 0 0y Tc -0.008 Tw 79.09

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