



Attending Provider's Statement of Competency

Send to: Group LTD Claims, PO Box 14333, Lexington, KY 40512
Customer Service Toll Free: 800-538-4583 Fax: 610-807-8221

Documents can be returned electronically at www.guardianlife.com/forms. Select the "Benefits through work" option and click the "Secure Channel" link to send your private information.

Name: _____ Date of Birth: _____
Claim #: _____ Plan #: _____

PLEASE COMPLETE THE FOLLOWING:

1. Do you believe that your patient is competent to endorse checks and direct the use of the proceeds there of?

Yes: ☐ No: ☐

If no, as of what date did your patient first become unable to endorse checks and direct the use of the proceeds thereof?

Date: _____

2. Are you aware if your patient's spouse or other relative is currently handling or has handled their affairs? If yes, please provide the contact information below:

Contact Name: _____

Address: _____

Telephone #: _____

3. Has your patient regained the ability to endorse checks and direct the use of the proceeds thereof?

Yes: ☐ No: ☐

If yes, as of what date? Date: _____

Provider's Signature: _____ Date: _____

Printed Name: _____ Specialty: _____

Phone: _____ Fax: _____