

## Short term disability

## Your guide for a seamless process



For a simplified claim experience, file online: guardianlife.com





Are you filing your claim for maternity? Once you have delivered, contact Guardian to report your date and type of delivery. Please inform us if you are taking baby bonding time following your recovery.



We may need medical information to review your claim. Included is an authorization form. Please provide the authorization form to your physician(s) currently treating you for this condition. Your physician may require an alternate form.



To ensure timely payments, please keep Guardian and your employer informed of updates to your leave. If you are not able to return to work as planned, contact Guardian so that we can reach out to your physician(s) for updated information.



It's important your work state is indicated on the claim form. If you work from home and are unsure of your work state, please consult with your employer. If Guardian administers your State Paid Leave policy, you do not need to file a separate claim. We'll take care of that for you.



We will contact you, your employer or physician if any additional information is needed to make a claim decision. Claim reviews are generally completed within 10 business days, and you will be contacted when a decision is made.\*

Questions after submitting your claim? Contact Guardian at 800-268-2525. A Guardian representative is available to help you Monday through Friday, 8:00 am to 8:00 pm EST.



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

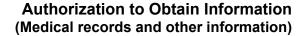
Or, you may complete the form and submit by fax to (610) 807-8270 or email to group\_std\_claims@glic.com
You may also send to: Group STD Claims, P.O. Box 14331, Lexington, KY 40512

Custor

You may also send to:								rvice toll-fr	ee: 1-800-268-2525	
EMPLOYEE SECTION	ON - PLEAS	SE PRINT AND COMPI	LETE <u>IN FU</u>	LL TO PR	REVENT DELA	AY IN P	ROCESSING			
1. EMPLOYEE NAME				:	2. PLAN NUM	PLAN NUMBER		IAME		
4. EMPLOYEE HOME MAILIN	IG ADDRESS		(	CITY		STATE	ZIP	5. EMPLOYE	EE TELEPHONE NUMBER	
6. WORK STATE		7. EMPLOYEE EMAIL ADDR	RESS							
8. MEMBER ID	9. DATE OF	BIRTH	10. SOCIAL S	SECURITY N	Y NUMBER				11. MALE	
									FEMALE	
12. IS DISABILITY DUE TO YOUR EMPLOYMENT? ☐ YES ☐ NO  IF "YES", HAVE YOU FILED A WORKERS' COMPENSATION CLAIM? ☐ YES ☐ N				NO	13. IS DISABILITY DUE TO AN ACCIDENT? YES NO  IF "YES", DO YOU INTEND TO FILE SUIT? YES NO				□NO	
14. IF YOU ANSWERED "YES" TO QUESTION (12) AND/OR (13), PLEASE PROVIDE THE DATE OF ACCIDENT / / TIME PLACE ACCIDENT DETAILS					IS DISABILITY DUE TO SERVICE IN THE MILITARY?					
	ISABILITY PLAI	NS AND SALARY CONTINUA	TION AND/OR S	SICK LEAVE	BENEFITS, PTO,	ETC.)?	YES NO	IF "YES", ATTA	PLOYMENT, PENSION, NO-FAULT ACH A COPY OF THE AWARD E PAPER IF NEEDED)	
PLEASE NOTE: CERTAI TO MEET THESE REQUI	COME TAX (MU N DISABILITY E REMENTS, A M	IST BE WHOLE DOLLAR AMO	OUNT OF AT LE  SUPPLEMENT  ME TAX WITHH	AST \$20 PEI FAL WAGES HOLDING (22	R WEEK AND MA	Y NOT RE	DUCE BENEFIT TO	D LESS THAN S		
five thousand dollars and the s	tated value of th urity number is r ng to the claim." <b>P</b>	e claim for each such violation.	ı." urposes. Your So	ocial Security	number will not be	e used or o	disclosed to anyone	for any other po	sterially false information or conceal subject to a civil penalty not to exceen urpose and will not be retained in an DATE	
PHYSICIAN SECTION 1. DIAGNOSIS(ES)	ON – PLEAS	SE COMPLETE <u>IN FUL</u>	LL AND RET	TURN TO	PREVENT DI		N PROCESSIN	G		
O IO DATIENTIO DIOADII ITV	DUE TO AVE	CMDLOWMENT DVC0 D	NO B) 400	DENT O	YES NO C	) DDEON	ANOV FLYES F	TNO DIMIL	TARY SERVICE THE TAR	
		EMPLOYMENT YES PLEASE INDICATE DATE OF		IDENI L	ESTIMATE	·		LIVERED)	TARY SERVICE YES NO	
PLEASE INDICATE TYPE	,	□ VAGINAL □ C-SEC		LTIPLE BIRT	THS ACTUAL	- '	(11 01102	.c.verteb)		
5. DATE SYMPTOMS FIRST	APPEARED	6. DATE OF FIRST VISIT	T FOR THIS CO	NDITION	7. A) DATES OF	TREATM	ENT FOR THIS CO	NDITION	8.	
1 1					7. B) DATE OF PATIENT'S NEXT APPOINTME			MENT	HEIGHT	
9. DATE PATIENT WAS TOTALLY DISABLED (UNABLE TO WORK)					1 1				WEIGHT LBS	
FROM / /	THRO	UGH / /								
10. IF PATIENT STILL DISABLED, GIVE DATE FOR  ANTICIPATED RELEASE TO RETURN TO WORK / /					11. DATES PATIENT WAS HOSPITALIZED (IF APPLICABLE)  FROM / / THROUGH / /					
12. SURGICAL DATE(S): CPT(S)/PROCEDURE(S)										
13. A) WOULD YOU SUPPORT THE PATIENTS RETURN TO WORK ON A LIMITED BASIS?  YES NO IF "YES", PLEASE PROVIDE RESTRICTIONS AND LIMITATIONS THAT WOULD BE I					14. A) WAS PATIENT REFERRED TO YOU BY ANOTHER PHYSICIAN? YES NO IF "YES", PLEASE GIVE NAME AND TELEPHONE NUMBER OF PHYSICIAN					
13. B) DURATION OF ABOVE RESTRICTIONS:					14. B) DID YOU REFER PATIENT TO ANOTHER PHYSICIAN? ☐ YES ☐ NO IF "YES", PLEASE GIVE NAME AND TELEPHONE NUMBER OF PHYSICIAN					
15. DO YOU BELIEVE THE PA PROCEEDS THEREOF?			CKS AND DIREC	CT THE						
					SPECIALTY					
PRINTED ADDRESS OF PHYSICIAN					TELEPHONE NUMBER ( )					
					TAX ID #					
SIGNATURE OF PHYSICIAN					DATE					



EMPLOYER SECTION – PLEASE PRINT AND COMPLETE IN FULL (QUESTIONS 1-25) TO PREVENT DELAY IN PROCESSING												
1. EMPLOYER NAME 2. PLAN NUMBER	2. PLAN NUMBER											
3. EMPLOYER ADDRESS CITY STATE ZIP	STATE ZIP											
4.1 F BRANCH OR AFFILIATE, PLEASE PROVIDE NAME OF PARENT EMPLOYER SOCIAL SECURITY OR TAX ID  5. DATE EMPLOYEE TERMINATED/RESIGNED  / /												
6. EMPLOYEE NAME  7. EMPLOYEE SOCIAL SECURITY NUMBER BIRTH / /												
9. EMPLOYEE JOB TITLE  10. DATE OF EMPLOYMENT  11. DATE EMPLOYEE EFFECTIVE FOR STD  12. EMPLOYEE INSUR  / / / CLASS	NCE											
13. CLAIMAN'TS PHONE NUMBER  14. NORMAL WORK  SCHEDULE:  MON TUES WED THURS FRI SAT SUN HOURS/WEEK  HOURS/DAY												
15. REASON FOR LEAVING WORK: 16. ACTUAL LAST DAY WORKED / / 17. HOURS WORKED ON LAST DAY	Y											
□ DISABILITY □ MATERNITY □ OTHER												
17. CAN THE EMPLOYEE'S JOB BE MODIFIED TO ALLOW FOR RETURN TO WORK?  18. DATE EMPLOYEE RETURNED TO WORK  PART TIME												
☐ YES ☐ NO ☐ MAYBE, DEPENDING ON RESTRICTIONS / / ☐ FULL TIME												
19. SALARY – (PER THE COMPANY SETUP) PLEASE PROVIDE: ☐ HOURLY ☐ WEEKLY ☐ BI-WEEKLY ☐ SEMI-MONTHLY ☐ MONTHLY ☐ YEARLY												
EMPLOYEE'S BASE SALARY (DO NOT INCLUDE BONUS, OVERTIME OR COMMISSIONS) \$ (PLEASE CHECK FREQUENCY ABOVE)												
EMPLOYEE'S TOTAL BONUS AND COMMISSIONS OVER LAST 24 MONTHS (IF APPLICABLE) \$ FROM / / TO / /												
EFFECTIVE DATE OF EMPLOYEE'S LAST SALARY CHANGE:												
<u>IF EARNINGS DEFINITION BASES SALARY ON PRIOR YEAR W-2</u> , PLEASE ATTACH A COPY OF THE PRIOR YEAR W-2 (IF EMPLOYED IN PRIOR YEAR) <u>OR</u> PROVIDE YEAR-TO-DATE SALARY: \$ FROM / / TO / /												
20. DOES THE EMPLOYEE CONTRIBUTE TO THE COST OF THEIR SHORT-TERM DISABILITY  10. DOES THE EMPLOYEE CONTRIBUTE TO THE COST OF THEIR SHORT-TERM DISABILITY  11. FOR ASSISTANCE WITH JOB ACCOMMOCATION STAY AT WORK OPPORTUNITIES, CONTACT  OUR VOCATIONAL REHABILITATION DEPT. AT 800-233-0691, OR, TO RECEIVE A CALL FROM OUR												
IF "YES", PLEASE BE SURE TO COMPLETE THE FOLLOWING ACCURATELY AND FULLY  VOC REHAB DEPT., PLEASE PROVIDE US WITH THE PERSON YOU WOULD LIKE US TO COMPLETE THE FOLLOWING ACCURATELY AND FULLY	ONTACT:											
% PAID BY EMPLOYEE, ☐ PRE-TAX ☐ POST TAX  PLEASE NOTE: SELF FUNDED DISABILITY PLAN BENEFITS ARE CONSIDERED SUPPLEMENTAL WAGES BY THE IRS (SEE IRS PUBLICATION 15A). IF YOUR DISABILITY PLAN IS SELF FUNDED, GUARDIAN WILL DEDUCT A MANDATORY 22% FEDERAL INCOME TAX WITHHOLDING FROM THE DISABILITY BENEFIT CHECKS THAT ARE ISSUED.												
22. A) DID THIS DISABILITY ARISE OUT OF EMPLOYMENT?												
B) HAS A WORKERS' COMPENSATION CLAIM BEEN FILED? YES NO												
23. DOES THIS EMPLOYEE HAVE OTHER GROUP COVERAGE THROUGH GUARDIAN?   LTD   LIFE   FML   STATE DISABILITY/PAID LEAVE   STATE PLAN #												
23(B) WHAT IS THE EMPLOYEE'S WORK STATE?												
24. JOB DESCRIPTION – Please fully complete the following details about the physical aspects of the claimant's job as performed in an 8-hour work day.  Please also attach a description of job duties, if available.												
NEVER   .25 – 2.5 DAILY   2.5 – 5.5 DAILY   5.5 – 8 DAILY   NEVER   .25 – 2.5 DAILY   2.5 – 5.5 DAILY   5.5 – 6	UOUSLY DAILY RS											
SIT	]											
STAND DRIVE D DRIVE												
LIFT/CARRY INDICATE AMOUNT/FREQUENCY BELOW REACH ABOVE	]											
0-10 LBS												
10-20 LBS	INDICATE ACTIVITY/FREQUENCY BELOW											
20-50 LBS	]											
50-100 LBS												
OVER 100 LBS												
25. I CERTIFY THAT I HAVE REVIEWED THE ABOVE INFORMATION AND THAT THE EMPLOYEE NAMED ABOVE HAS BEEN A FULL-TIME ACTIVE EMPLOYEE FOR WHOM PREMIUMS HAVE BEEN PAID.  AUTHORIZED EMPLOYER SIGNATURE DATE  PRINTED NAME OF AUTHORIZED PERSON TITLE  TELEPHONE NUMBER ( ) - EXT FAX NUMBER ( ) - EXT FAX NUMBER ( ) -												





Send to: Group STD Claims, P.O. Box 14331, Lexington, KY 40512 Customer Service: (800) 268-2525 FAX: (610) 807-8270

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

- I, the undersigned, AUTHORIZE any physician, medical or mental health professional, medical practitioner, hospital, clinic, healthcare or other medical or medically related facility, healthcare provider, pharmacy, pharmacy benefit manager, therapist, benefit plan administrator, business associate, insurer or reinsurer, consumer reporting agency subject to the Fair Credit Reporting Act, insurance support organization, insurance agent, employer, financial institution, Governmental Agency including The Social Security Administration, The Veteran's Administration or any other organization or person having any knowledge of The Insured or The Insured's health to give The Guardian Life Insurance Company of America ("Guardian") or its employees and agents, or its authorized representatives, or third parties, any information in its possession about The Insured. This information includes, but is not limited to, medical information as to cause, treatment, diagnoses, prognoses, consultations, examinations, tests or prescriptions with respect to The Insured's physical or mental condition or treatment of The Insured. This may include (but is not limited to) HIV infection, any disorder of the immune system, including acquired immune deficiency syndrome (AIDS), mental illness or use of alcohol or drugs. This information also includes non-medical information concerning The Insured, The Insured's occupation, employment history, driving history, earnings or finances or information otherwise needed to determine policy claim benefits that may be due The Insured.
- I, the undersigned, UNDERSTAND that this authorization is part of the policy's Proof of Loss requirement and if I revoke or fail to sign this authorization or alter its content in any way, it may affect the handling of The Insured's claim, including the denial of benefits under The Insured's policy. Any information obtained will not be released by Guardian to any person or organization except to: affiliates (including but not limited to Berkshire Life Insurance Company of America); reinsuring companies; other persons (including but not limited to The Insured's attending medical provider), or insurance support organizations performing business or legal services in connection with The Insured's claim or application for insurance, or as may be otherwise lawfully required, or as I may further authorize. Information disclosed pursuant to this authorization is no longer covered by federal privacy rules and may be redisclosed pursuant to this authorization or as otherwise permitted or required by law. In the event that my coverage with Guardian requires me to pursue benefits available from the Social Security Administration, I further authorize Guardian to disclose information contained in my claim file with third parties specializing in social security disability claims.
- **I, the undersigned, UNDERSTAND** that I have the right to revoke this authorization in writing at any time by sending a written request for revocation to Guardian at P.O. Box 14331, Lexington, KY 40512. I understand that a revocation is not effective to the extent that Guardian has already relied on this authorization, or to the extent that the company has a legal right to contest a claim under an insurance policy or to contest the policy itself.
- I, the undersigned, UNDERSTAND some states require that I be informed that: "Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, may be committing a fraudulent insurance act, which is a crime and subject to criminal prosecution, substantial civil penalty and the stated value of the claim for each violation."
- I, the undersigned, AGREE the information obtained with this authorization may be used by Guardian to determine eligibility for benefits under The Insured's policy. A photocopy of this form is as valid as the original, and I may request one. This form is valid up to 24 months (12 months in Kansas) from the date shown below.
- I, the undersigned, AUTHORIZE the Social Security Administration to release information or records about (The Insured) to Guardian or its authorized representative or third parties. This information is to be released in order to properly adjudicate The Insured's claim or continue The Insured's eligibility for benefits. Please release detailed earnings for up to the last ten years and/or summary record of total earnings and/or information from master benefit records regarding award, denial or continuing benefits. I declare that all answers, statements and information made or given by me, or at my direction, in connection with this claim are and have been complete and true.

Signature of Insured (or authorize	zed representative)	Relationship	Date		
Name of Insured					
Address					
Claim #	Policy #		Date of Birth / /		

GG-013843 (7/16)



## Fraud Warning Statements

The laws of several states require the following statements to appear on the claim form:

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

**Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**Arkansas, West Virginia**: 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.

**Arizona:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**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.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or 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 agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Connecticut, Iowa, Nebraska and Oregon:** Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

**Delaware, Indiana and Oklahoma:** WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

**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.

**Idaho**: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

**Kansas**: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

**Louisiana and Texas:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.



**New Mexico**: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

**Maine, Tennessee and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefit.

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

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is quilty of a crime.

**New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**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.

**Ohio:** Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**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 such person to criminal and civil penalties.

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

**Vermont:** It is a crime for any person knowingly to provide material false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company, for any person knowingly to provide material false, incomplete, or misleading information concerning the sale of insurance or the status of an insurer, or for any person to misappropriate the funds of an insured or an applicant for insurance. Penalties include imprisonment, fines, and denial of insurance benefits.

**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.