



Massachusetts Paid Medical Leave Claim Packet

Instructions for filing your Guardian – Massachusetts Paid Medical Leave (PML) Claim (form MA PML-1). If you are filing a claim for Massachusetts Paid Family Leave, use form (MA PFL-1).

This packet contains the forms that are needed to process your claim for Massachusetts Paid Medical Leave Benefits. Please keep this page for future reference and for the Guardian contact information.

Note: If you are filing a claim for intermittent Leave (periods of less than a full workday), benefits are only considered after you have satisfied the required 7 day wait period, and, the earlier of the date you have accumulated an additional full workday of Leave, or, a period of 30 calendar days have elapsed since your benefits commenced. **As such, we encourage you to not file your claim until you have used a full day of leave time following satisfaction of the 7 day wait period, or, 30 days have elapsed since your benefits have commenced.**

Employee / Claimant Responsibilities:

- 1). It is your responsibility to file your claim within 30 days following the start of your medical leave. Late filing could result in a claim denial or delay. See above **Note**.
- 2). Your employer should complete and sign their portion (Part C) of the claim form and return it to you for your completion and filing of the remaining sections.
- 3). You should fully complete your portions of the claim form (Part A), and then supply your treatment provider with the form so that they can fully complete their section (Part B)
- 4). We recommend that you submit ALL sections of the claim (employee, employer and treatment provider), along with a signed Form GG-013843 PML (Authorization) at the same time. Separate submissions could delay the handling of your claim.
- 5). If you would like to enroll in direct deposit, please complete and include the attached GG016672 PFML form. **Note:** Direct deposit **is not** available for intermittent leaves, or for situations where your employer is continuing to pay you wages and they are requesting reimbursement.
- 6). It is very important that ALL sections are completed fully, accurately, and legibly.
- 7). Your signature acknowledges that, to the best of your knowledge, the forms have been completed accurately.
- 8). If you are also covered under a Guardian Short Term Disability plan, completion and submission of this form may enable us to establish both your STD and MA PML claims. **However**, please be advised that different requirements apply to both plans, therefore, eligibility for one, does not guarantee eligibility for the other.

Employer Responsibilities:

- 1) Your employer should fully complete their portion (Part C) of the claim form and return it to you for further completion and submission. This ensures that your information remains private.
- 2) It is very important that ALL sections are completed fully, accurately, and legibly. Missing, incomplete, or illegible information could delay payment of your claim
- 3) To ensure the accurate taxation of your MA PML benefits, your employer should fully complete questions #7 and #8 of Part C.
- 4) To ensure the accurate calculation of your MA PML benefit amount, your employer should be sure to follow the instructions and example in Part C, question #10, for recording your earnings under the PML program.
- 5) If you also have Guardian Short Term Disability coverage, your employer should fully complete the STD-PML Supplement portion. This enables us to capture your earnings, taxability, effective date, and job duties as related to the Short Term Disability coverage.

******I am unable to provide a signature due to the COVID-19 pandemic. I understand that my typewritten name has the same force and effect as my signature.**

Guardian Contact / Claim Filing Information

Guardian Insurance
Paid Leave Claims
P.O. Box 14806
Lexington KY 40512

Customer Service # 1-800-268-2525 Fax # 610-807-2684 Email: paid_leave_claims@glic.com



MASSACHUSETTS – PAID MEDICAL LEAVE CLAIM FORM

Telephone # 1-800-268-2525 Fax # 610-807-2684 Email: paid_leave_claims@glic.com

PART A - Please Print		TO BE COMPLETED BY THE CLAIMANT		Guardian Plan # _____		
1. Claimant's Name: Last First Middle			2. Birth Date		3. Social Security Number	
4. Home Address – <u>required</u> (Street, Apt #, City, State, Zip Code)					5. County	
6. Mailing Address – if different (Street, Apt #, City State, Zip Code)			7. ☐ Male ☐ _____ ☐ Female		8. Occupation	
9. Phone No. (____) _____ E-Mail Address _____						
10a. What was the last day that you actually worked before your medical leave began?				Month	Day	Year
10b. Reason for separation: ☐ Illness/Accident/Maternity ☐ Terminated ☐ Quit						
11. What is the first day you are unable to work due to present medical leave?						
12. If you have a return to work date, list date: ☐ Actual ☐ Possible						
13. What type of Leave claim are you filing? ☐ Continuous ☐ Intermittent						
14. Please supply dates of leave: FROM ____/____/____ THROUGH ____/____/____ ☐ Estimated ☐ Actual						
15. If intermittent leave is being used, please describe the leave schedule (days and times) you will be using. (ie. 2 hours every M, W and F) _____						
16. Do you have more than one employer? ☐ Yes ☐ No						
a. If yes, are you taking PML with the other employer? ☐ Yes ☐ No						
b. If yes, are you taking PML with the other employer for the same period of time you are making this Leave claim? ☐ Yes ☐ No						
17. Describe your medical condition (how, what, where, when) _____						
18. Was this injury/illness caused by your job? ☐ Yes ☐ No If Yes, date of work related injury/illness: ____/____/____ If Yes, have you or your employer filed or intend to file a WC claim? ☐ Yes ☐ No						
19. Identify the physician or hospital treating you for this medical leave: Name: _____ Address: _____ Telephone: (____) _____						
20. If your Paid Medical Leave is for a maternity claim, and if you have Paid Leave time available to you, do you intend to use Paid Family Leave for Bonding following completion of your Paid Medical Leave? ☐ Yes ☐ No						
a. If you answered "No" above, we will NOT begin a Paid Family Leave (Bonding) claim immediately after your Paid Medical Leave claim						
b. If you answered "Yes" above, will you start your Paid Family Leave (Bonding) claim immediately after your Paid Medical Leave claim? ☐ Yes ☐ No If yes, will you be using ☐ continuous or ☐ intermittent leave?						
c. If Intermittent, please supply your anticipated leave schedule (days/hours) _____						
Note: If you plan to postpone your use of Paid Family Leave (Bonding) until a later date, you will be required to complete and submit a Paid Family Leave Claim form (MA PFL-1) at that time.						
21. Other Income – You must answer each question listed below for the period of paid leave covered by this claim:						
a. Have you tried working any days since your medical leave started? ☐ Yes ☐ No If yes, Employer Name _____ Dates Worked _____ to _____						
b. Have you been paid for any days after your last day of work? ☐ Yes ☐ No If yes, give dates _____ to _____ and amount \$ _____ per _____.						
22. Since your last day of work have you received, claimed, or applied for any sources of income listed below: If yes, give dates _____ to _____ and amount \$ _____ per _____.						
Check box(es) below for type of pay received						
a. Any governmental Disability / Retirement Benefits? ☐ Yes ☐ No (explain _____)						
b. Other disability benefits provided by your employer or union? ☐ Yes ☐ No (explain _____)						
c. Unemployment Insurance Benefits? ☐ Yes ☐ No (explain _____)						
d. Workers Compensation or similar Benefits? ☐ Yes ☐ No (explain _____)						
e. Other _____						
Certification and Signature Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits. I am hereby making a request for paid medical leave benefits under the Massachusetts Paid Medical Leave Law. My signature affirms that the information I am providing is true and accurate to the best of my knowledge and belief. I am unable to provide a signature due to the COVID-19 pandemic. I understand that my typewritten name has the same force and effect as my signature. Sign and date here						

Claimant's Name: _____ Plan # _____		Social Security Number _____
PART B- Please print	MEDICAL CERTIFICATE (TO BE COMPLETED BY YOUR DOCTOR AFTER YOUR LEAVE BEGINS)	
1a. Patient has been under my care for this period of medical leave: FROM ____/____/____ THROUGH ____/____/____ b. Frequency of treatment: _____ c. Patient was last treated by me on: _____ ➡ ____/____/____		
2a. Enter the date the patient was first unable to perform their work due to this medical leave: ➡ ____/____/____ a. Type of leave required by your patient ☐ Continuous ☐ Intermittent b. Inclusive dates for which you are approving this leave: FROM ____/____/____ THROUGH ____/____/____ c. If intermittent, please supply the schedule for which medical leave is being approved: (ie. _0_ Sun _8_ Mon _0_ Tue _8_ Wed - etc) ____SUN ____MON ____TUE ____WED ____THUR ____FRI ____SAT ____VARIES (explain) _____		
3. Recovery date: ☐ Estimated ☐ Actual ➡ ____/____/____		
4. Diagnosis: (nature of this medical leave which prevents patient from working) _____ ICD Code: _____ Clinical data to support diagnosis and restrictions : _____		
5a. If pregnancy, provide date of delivery: ☐ Estimated ☐ Actual ➡ ____/____/____ b. Complications, if any. _____ c. If pregnancy terminated, enter the date: ➡ ____/____/____ And identify the reason: ☐ Normal delivery ☐ C-Section ☐ Miscarriage ☐ Abortion		
6a. Date(s) of emergency room care / hospitalization / Rehab: FROM ____/____/____ THROUGH ____/____/____ b. Name and address of any specialist treating patient: _____		
7. Type of surgery: _____ Date of Surgery ____/____/____ ☐ Scheduled ☐ Actual Is surgery for cosmetic purposes only? ☐ Yes ☐ No		
8. In your opinion, was this disability due to an accident or condition which developed due to the nature of the work? ☐ Yes ☐ No		
9. Was this patient referred to you? ☐ Yes ☐ No If yes, please supply the information below if available. Name of referring doctor _____ Referring doctor's telephone #: _____		
10. Do you believe this patient is mentally capable of handling their own affairs, including the use of benefits? ☐ Yes ☐ No		
11. I certify that the above statements truly describe the patient's need for medical leave / disability and the estimated duration thereof: _____ (Print Doctor's Name and Medical Degree) _____ (Original Signature of Doctor Required) _____ (Date Signed) _____ (Address) _____ (Certificate License No. and State) _____ (City) _____ (State) _____ (Zip Code) _____ (Specialty of Treating Physician) Telephone Number: (____) _____ FAX Number: (____) _____		

Claimant's Name: _____ Plan # _____		SOCIAL SECURITY NUMBER 																														
PART C	TO BE COMPLETED BY YOUR EMPLOYER OR COMPANY REPRESENTATIVE																															
1. Private Plan Coverage (Guardian approved plan replaces State Plan) a. Is claimant covered under your Guardian MA PML Plan? ☐ Yes ☐ No If Yes, employee's coverage effective date ____/____/____ b. Is claimant also covered by a Guardian Short Term Disability plan? ☐ Yes ☐ No If Yes, please supply the Guardian 6-digit STD plan # _____ If Yes, be sure to fully complete the STD-PML Supplement c. Claimant's hire date: ____/____/____ 2. Last Actual Day Worked before this medical leave ____/____/____ Number of hours worked that day _____ a. Reason for separation from work if other than medical leave _____ b. Has claimant Returned To Work (RTW)? ☐ Yes ☐ No If "Yes", give date ____/____/____ c. If the RTW was intermittent, list dates/hours: _____ 3. Check the hours and days of the week the employee normally works. (ie. 0_SUN_8_MON_8_TUE_8_WED_0_THUR_8_FRI_8_SAT_VARIES) ____SUN____MON____TUE____WED____THUR____FRI____SAT____VARIES 4. In the preceding 52 weeks has the employee taken leave for: ☐ PML ☐ PFL ☐ Both PML and PFL ☐ None 5. If leave was used, enter the total PFL and PML time taken in the last 52 weeks: PFL = _____ Dates ____/____/____ THROUGH ____/____/____ PML = _____ Dates ____/____/____ THROUGH ____/____/____ 6. Continued Pay (do not enter wages earned prior to medical leave) a. Have you paid or expect to pay the claimant for any period after the last day of work? ☐ Yes ☐ No b. If "yes" give dates: FROM ____/____/____ THROUGH ____/____/____ c. Amount \$ _____ per ☐ week ☐ day ☐ hour ☐ _____ if amount varies attach list of dates and amounts. d. Check the box that best describes the monies paid in items a – c above. 1. ☐ Regular weekly wages / sick pay / PTO 2. ☐ Regular vacation (if designated for a specific time period) 3. ☐ Difference between regular weekly wage and PML benefits 4. ☐ Other _____ e. If paying full wages to your employee, are you requesting reimbursement through the MA PML benefits payable to your employee? ☐ Yes ☐ No IMPORTANT: Questions 7 and 8 are needed to accurately tax any PML benefits 7. Does the employee contribute to the cost of the MA PML coverage? ☐ Yes ☐ No If No, skip to question #9 a. If Yes, what percentage of this claimant's overall MA PML premium does the employee pay? _____% b. Does this claimant contribute to their MA PML premiums on a: ☐ Pre-tax basis ☐ Post-tax basis		8. Is this employee subject to: FICA - Social Security taxes? ☐ Yes ☐ No FICA - Medicare taxes? ☐ Yes ☐ No 9. WORKERS' COMPENSATION LIABILITY a. Is the claimant's PML claim in any way related to his or her work, or happen while on your premises? ☐ Yes ☐ No b. If "Yes", has a Workers' Compensation claim been filed on behalf of this claimant? ☐ Filed ☐ Intend to file ☐ Not filing (reason) _____ 10. How to determine Base Period gross wage: A BASE PERIOD is the last four completed calendar quarters preceding the start date of disability. <i>Example: Disability began 1/23/2021, the BASE Period is 1/1/2020 through 12/31/2020. See below</i> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="padding: 5px;">Completed Quarter</th> <th style="padding: 5px;">Quarter End Date</th> <th style="padding: 5px;">Gross Wages</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">1st Q prior to disability</td> <td style="padding: 5px;">12/31/20</td> <td style="padding: 5px;">\$15,000.00</td> </tr> <tr> <td style="padding: 5px;">2nd Q</td> <td style="padding: 5px;">9/30/20</td> <td style="padding: 5px;">\$22,500.00</td> </tr> <tr> <td style="padding: 5px;">3rd Q</td> <td style="padding: 5px;">6/30/20</td> <td style="padding: 5px;">\$17,250.00</td> </tr> <tr> <td style="padding: 5px;">4th Q</td> <td style="padding: 5px;">3/31/20</td> <td style="padding: 5px;">\$19,200.00</td> </tr> </tbody> </table> Please complete the below with "actual" Base Period Gross Wages: <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="padding: 5px;">Completed Quarter</th> <th style="padding: 5px;">Quarter End Date</th> <th style="padding: 5px;">Gross Wages</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">1st Q prior to disability</td> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> </tr> <tr> <td style="padding: 5px;">2nd Q</td> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> </tr> <tr> <td style="padding: 5px;">3rd Q</td> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> </tr> <tr> <td style="padding: 5px;">4th Q</td> <td style="padding: 5px;"></td> <td style="padding: 5px;"></td> </tr> </tbody> </table> ☐ Please affirm that, to the best of your knowledge, this employee has satisfied the employment and eligibility requirements of the State of Massachusetts Paid Leave program.	Completed Quarter	Quarter End Date	Gross Wages	1 st Q prior to disability	12/31/20	\$15,000.00	2 nd Q	9/30/20	\$22,500.00	3 rd Q	6/30/20	\$17,250.00	4 th Q	3/31/20	\$19,200.00	Completed Quarter	Quarter End Date	Gross Wages	1 st Q prior to disability			2 nd Q			3 rd Q			4 th Q		
Completed Quarter	Quarter End Date	Gross Wages																														
1 st Q prior to disability	12/31/20	\$15,000.00																														
2 nd Q	9/30/20	\$22,500.00																														
3 rd Q	6/30/20	\$17,250.00																														
4 th Q	3/31/20	\$19,200.00																														
Completed Quarter	Quarter End Date	Gross Wages																														
1 st Q prior to disability																																
2 nd Q																																
3 rd Q																																
4 th Q																																
<table style="width: 100%;"> <tr> <td style="width: 60%;">Employer Name / Division # _____</td> <td style="width: 40%;">Phone #: _____</td> </tr> <tr> <td>Address _____</td> <td>Signed _____</td> </tr> <tr> <td>Date _____ City, State, Zip _____</td> <td>Print or Type Name _____</td> </tr> <tr> <td>Federal EIN: _____</td> <td>Email _____</td> </tr> </table>			Employer Name / Division # _____	Phone #: _____	Address _____	Signed _____	Date _____ City, State, Zip _____	Print or Type Name _____	Federal EIN: _____	Email _____																						
Employer Name / Division # _____	Phone #: _____																															
Address _____	Signed _____																															
Date _____ City, State, Zip _____	Print or Type Name _____																															
Federal EIN: _____	Email _____																															

STD-PML Supplement – Complete ONLY if this employee is covered under your Guardian STD plan

Claimant's Name: _____ Plan # _____	SOCIAL SECURITY NUMBER _____ _____ ____
STD-PML Supplement	TO BE COMPLETED BY YOUR EMPLOYER OR COMPANY REPRESENTATIVE

1. If this employee is also covered under your Guardian STD plan, please supply the following:

Base Earnings \$ _____ Frequency _____ Date of last salary change _____

Bonus (over last 12 or 24 months) \$ _____ * Timeframe for Bonus _____ through _____
 Commissions (over last 12 or 24 months) \$ _____ * Timeframe for Commissions _____ through _____
 * please refer to your STD contract and supply the average bonus and / or commissions for the timeframe indicated (12 or 24 months) and as of your STD plan's redetermination date.

If STD earnings are based on prior year W2, please attach W2, or supply the W2 earnings \$ _____

If employed for part of the year, please supply the year to date earnings \$ _____

Please supply the timeframe for the partial year earnings _____ through _____

2. Does this employee contribute to the cost of STD coverage? ☐ Yes ☐ No

a. If YES, what percentage of this claimant's overall STD premium does the employee pay? ____ %

b. If YES, does this claimant contribute to their STD premiums on a:

☐ Pre-tax basis

☐ Post-tax basis

c. Is this a Gross Up / Bonus Back (non- taxable) arrangement? ☐ Yes ☐ No

3. Employee's STD effective date ____|____|____

4. JOB DESCRIPTION – Please fully complete the following details about the demands of the claimant's job as performed in an 8-hour work day. Please also attach a description of job duties, if available.

	Never	Occasionally .25-2.5 daily hours	Frequently 2.5-5.5 daily hours	Continuously 5.5- 8 Daily hours		Never	Occasionally.25 -2.5 daily hours	Frequently 2.5- 5.5 daily hours	Continuously 5.5-8 daily hours
Sit					Walk				
Stand					Drive				
Lift/Carry	INDICATE FREQUENCY BELOW				Reach above				
0-10 LBS					Bend/Stoop				
10-20 LBS					Use hands for:	Indicate Frequency below			
20-50 LBS					Pushing/ pulling				
50-100 LBS					Fine manipulation				
OVER 100 LBS					Stress level	☐ Low ☐ Moderate ☐ High ☐ Very high			

Employer Name / Division # _____	Phone #: _____
_____ Signed _____	Date _____ City, _____
State, Zip _____	Print or Type Name _____
Federal EIN: _____	Email Address: _____

Send to: Paid Leave Claims, P.O. Box 14806, Lexington, KY 40512
Customer Service: (800) 268-2525 FAX: (610) 807-2684
Documents can be returned securely at www.GuardianAnytime.com.

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 14806, 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 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.

I am unable to provide a signature due to the COVID-19 pandemic. I understand that my typewritten name has the same force and effect as my signature.

Signature of Insured _____ Relationship _____ Date _____

Name of Insured _____

Address _____

Claim # _____ Policy # _____ Date of Birth _____



Direct Pay Enrollment and Authorization for Paid Leave Claim Programs

To enroll in Direct Deposit, please supply the following information. If unable to physically sign this form, Guardian will accept a typewritten name in lieu of your signature, however, you must check the box below each signature line certifying that you understand that your typewritten name has the same force and effect as your signature.

NOTE: Direct Deposit is not available if you are filing a claim for intermittent leave, or in situations where Guardian is reimbursing your Employer due to their continued payment of wages. As a result, Direct Deposit will not be implemented in these situations.

For faster service please:

1. Complete this form on-line
2. Print, sign and scan it or use interim accommodation of typing your name in the signature line
3. Save the completed form to your computer
4. Upload via our [Secure Channel](#)

To mail this form:

Guardian Insurance
Paid Leave Claims
PO Box 14806, Lexington KY 40512

To fax the form:

(610)-807-2684

Following Guardian's receipt of your request, please allow up to 10 business days for set up of your direct deposit. If you have any questions about completing this form, please contact us at (800) 268-2525.

**** Please be advised that not all claims and plans are subject to direct deposit availability
** Complete Required Information below**

1. Claimant Name: **Group #:** **Claim Number (if known):**

2. Account Type:

☐ Checking Account or ☐ Savings Account

Bank Name:

Bank Routing Number (ABA#):

Bank Account Number:

**Required Information*

101

Name on Bank Account
Street Address
City, State, Zip

Date: _____

Pay to the order of: _____ DOLLARS

Memo: _____

⑆000067894⑆ 523456789⑆ 0101

Nine-digit Routing Number Account Number Do not include the check sequence number

3. Sign and date this authorization:

I authorize Guardian Life Insurance Company of America ("Company") to deposit any benefits I am eligible to receive directly into the account and bank I have indicated above or to such other account as the bank or any successor bank designates as my account. I also authorize the Company to debit my account for any deposits made in error. I also understand that the direct deposit service will stay in effect until I notify the Company in writing of cancellation or until I am no longer eligible for or due payments, whichever comes first. **If you are also covered under another Guardian Disability / Paid Leave plan, this request will also apply to those coverages / claims, if applicable, and should they be approved.** I understand that I have the opportunity to view my EOBs and payment history via registration on GuardianAnytime.com.

☐ Check this box if you **do not** want to receive paper EOBs in the mail if your direct deposit request is approved.

Claimant Signature

Date