NEW YORK DBL State Disability Claim Packet

Guardian

Instructions for filing your Guardian - New York DBL Claim (NY DB-450)

This packet contains the forms that are needed to process your claim for New York State Disability Benefits. Please keep this page for future reference and for the Guardian contact information.

Employee / Claimant Responsibilities:

1). It is your responsibility to file your claim within 30 days following the start of your disability. Late filing could result in a claim denial or reduction.

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.

3). You should fully complete your portion of the claim form (Parts A and questions 1 through 3 in Part B), 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) at the same time. Separate submissions could delay the handling of your claim.

5). It is very important that ALL sections are completed fully, accurately, and legibly. Missing, incomplete, or illegible information could delay payment of your claim.

6). Your signature acknowledges that, to the best of your knowledge, the forms have been completed accurately and truthfully.

Employer Responsibilities:

1) As the employer, you should fully complete your portion (Part C) of the claim and return it to your employee for further completion and submission.

2) It is very important that ALL sections are completed fully, accurately, and legibly. Missing, incomplete, or illegible information could delay payment of the claim.

3) To ensure the correct calculation of your employee's NY DBL benefit amount, use the table in Part C to accurately enter the gross wages they earned during the last eight weeks prior to disability.

4) If your employee has Guardian Short Term Disability coverage, you should also complete the STD-PML Supplement portion. This enables us to capture the employee's earnings, taxability, effective date, and job duties as related to the Short Term Disability coverage.

Guardian Contact / Claim Filing Information
Guardian Insurance
State Disability Claims
P.O. Box 14332
Lexington KY 40512
Customer Service # 1-800-268-2525 Fax # 610-807-2953 Email: State_Disability_Claims@glic.com

New York State Disability Benefits
STATEMENT OF RIGHTS

NEW YORK STATE | Workers' Compensation Board

If you are unable to work due to a non-occupational illness or injury, you may be entitled to disability benefits.

1. You may be entitled to statutory disability benefits for a non-work-related injury or illness (including disability due to pregnancy) beginning with the eighth consecutive day of disability. Disability benefits are paid **directly to you** by your employer's insurer, **not** through your employer, unless your employer is an approved self-insurer. You can take up to 26 weeks of disability at 50% of your average weekly wage, capped at $170 per week. Generally, your average weekly wage is the average of your last eight weeks of pay prior to starting disability. Your employer or union may provide different benefits, at least as favorable as statutory, under an approved disability benefits plan or agreement.
2. If you also take New York State (NYS) Paid Family Leave (PFL), your combined total disability leave and PFL in any consecutive 52-week period may not exceed 26 weeks. You cannot take PFL and disability leave at the same time.
3. You can be treated by any physician, podiatrist, chiropractor, dentist, nurse midwife, or psychologist who can certify your disability. Your medical bills are not covered, unless your employer and/or union provides for the payment of medical bills under an approved disability benefits plan or agreement.
4. Your employer may **not** ask you to waive your right to disability benefits. Employers may collect a maximum contribution of 60 cents/week to offset the insurance premium (unless the additional contribution is part of an approved plan). **You cannot be discriminated or retaliated against for requesting or taking disability benefits.**
5. Your employer or employer's insurer is required to begin payment or issue a ***Notice of Denial (Form DB-DEN)*** or ***Notice of Rejection (Form DB-451)*** within 18 days of your first day of disability leave or receipt of your completed claim, whichever is later. If you receive ***Form DB-DEN***, you will also receive ***Form DB-451*** with additional information within 45 days of your first day of disability leave or the receipt of your completed claim, whichever is later. If after these 45 days, you have not received benefits or ***Form DB-451***, promptly contact the NYS Workers' Compensation Board (Board) at **(877) 632-4996**. NOTE: If you receive ***Form DB-451*** and disagree, you may request a review by writing to the Board at the bottom right address.

To file a claim:

1. Obtain a ***Notice and Proof of Claim for Disability Benefits (Form DB-450)***, either from the Board at wcb.ny.gov, or from your employer, or your employer's insurer.
2. Follow instructions to complete/submit the form, which includes sections your employer and health care provider must complete.
3. Submit the form to your employer's insurer within 30 days of your first day of disability. If your claim is not paid promptly, contact your employer or their insurer. If you file late, you may not be paid for any disability period more than two weeks before the date you filed. Late filings may be excused if you can show it wasn't reasonably possible to file earlier. No benefits are payable if you file more than 26 weeks after your disability begins, or after you return to work.

Do not assume that your employer has filed a claim on your behalf: filing a claim is your responsibility.

Note: If your disability is the result of an automobile accident, and you have filed a claim for no-fault benefits, **you must** also file a ***Form DB-450*** for disability benefits. If you do not file for disability benefits, the no-fault insurer may reduce your no-fault payments.

IMPORTANT: In such cases, if you are not entitled to disability benefits, immediately advise the no-fault insurer.

FOR HELP OBTAINING A CLAIM FORM OR FILLING IT OUT, OR OTHER QUESTIONS ABOUT BENEFITS FOR YOUR NON-WORK-RELATED INJURY OR ILLNESS, PLEASE CALL (877) 632-4996. A BOARD REPRESENTATIVE WILL HELP.

This information is a simplified presentation of your rights as required by Section 229 of the Disability and Paid Family Leave Benefits Law.
Your employer's disability benefits insurance carrier is:

The Guardian Life Insurance Company of America
10 Hudson Yards, New York, NY 10001
800-268-2525

PRESCRIBED BY THE CHAIR,
WORKERS' COMPENSATION BOARD
NYS Workers' Compensation Board
Disability Benefits Bureau
PO Box 9029, Endicott, NY 13761-9029

WCB.NY.GOV

DB-271S (12/23)

How to request Disability Benefits

Do not submit this form prior to your first date of disability. You must submit your completed claim form within 30 calendar days of your first day of disability to avoid losing benefits. Keep a copy of all forms and documentations for your records.

1. If you are using this form because you became disabled **while employed** or you became disabled **within four (4) weeks after termination of employment**, your completed claim should be submitted to your employer or your last employer's insurance carrier. You may find your employer's disability insurance carrier on the Workers' Compensation Board's website, www.wcb.ny.gov, using Employer Coverage Search.
2. If you are using this form because you became **disabled after having been unemployed for more than four (4) weeks after termination of employment**, your completed claim MUST be mailed to: **Workers' Compensation Board, Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029**. If you answered "Yes" to question 13.B.4., please complete and attach Form DB-450.1.

Note: This form has a section to be filled out by your healthcare provider, and a section to be completed by your employer. Before providing the form to your employer, fill out your section and make a copy to keep.

- The health care provider is required to return the form to you with Part B completed within seven days. If there is a delay, you must wait to submit the form to your insurance carrier. If Part B is not complete (or has incomplete answers) there may be delay in the payment of benefits.
- Your employer is required to return the form to you with Part C completed within three business days. If there is a delay, you do not have to wait to proceed – you should send the form to your insurance carrier. They cannot deny your request for disability benefits solely because your employer failed to fill out their section.

Important to know:

You will receive a response within 18 days of your first day of disability leave or the employer or carrier's receipt of your completed claim, whichever is later. If your claim is rejected, you will receive either a Notice of Denial of Claim for Disability Benefits (Form DB-DEN) or a Notice of Total or Partial Rejection of Claim for Disability Benefits (Form DB-451). If you receive a Form DB-DEN, you will receive a form DB-451 with additional information within 45 days of your first day of disability leave or the employer or carrier's receipt of your completed claim, whichever is later.

If you do not receive a response within 18 days (or the Form DB-451 within 45 days) or if you have questions about your disability benefits claim, please call your employer's insurance carrier. For general information about disability benefits, please visit www.wcb.ny.gov or call the Board's Disability Benefits Bureau at (877) 632-4996.

Notice and Proof of Claim for Disability Benefits (Form DB-450) Instructions

PART A - EMPLOYEE INFORMATION (to be completed by the employee)

You must answer all questions in this part.

Question 9: Enter the best estimate of average gross weekly wage. Fill out the table using your gross wages from your last employer prior to disability. If you had more than one employer in the previous 8 weeks prior to your disability, include all wage information from those employer(s) as well.

Step 1: Add all gross wages received (before any deductions) over the last eight weeks prior to the first day of disability, including overtime and tips earned. (See Step 3 for instructions for calculating bonuses and/or commissions.)

Step 2: Divide the gross wages calculated in step one by eight (or the number of weeks worked if less than eight) to calculate the average weekly wage.

Step 3: If you received bonuses and/or commissions during the 52 weeks preceding the first day of disability, add the prorated weekly amount to the average weekly wage. To determine the prorated weekly amount, add all bonuses/commissions earned in the preceding 52 weeks and then divide by 52.

PART B - HEALTH CARE PROVIDER'S STATEMENT (to be completed by the health care provider)

The health care provider must fill in this statement completely and return it within seven days of receipt of this form.

PART C - EMPLOYER INFORMATION (to be completed by the employer)

The employer must complete and return to the employee within three business days of receipt.

Question 6: If wages were continued during disability, specify how wages were paid – through salary continuation, use of paid time off, sick time, etc.

Question 8: Enter the wages earned by the employee during the last eight weeks preceding the first day of disability. The gross amount paid is the employee's gross weekly pay, including any overtime and tips earned for that week, plus the weekly prorated amount of any bonus or commission received during the preceding 52 weeks. (For detailed steps, see Question 9 in the Part A instructions). Calculate the gross average weekly wage by adding up the gross amounts paid, and then dividing the total by eight (or number of weeks worked if less than eight).

New York State

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

PART A - CLAIMANT'S INFORMATION (Please Print or Type)

1. Last Name: _____ First Name: _____ MI: ___

2. Mailing Address (Street & Apt. #): _____

City: _____ State: _____ Zip: _____

3. Daytime Phone #: _____ Email Address: _____

4. Social Security #: _____ - ____ - _____ 5. Date of Birth: ___ / ___ / _____ 6. Gender: ☐ M ☐ F ☐ X

7. Describe your disability (if injury, also state how, when and where it occurred): _____

_____

8. Date you became disabled: ____ / ____ / _____ Did you work on that day?: ☐ Yes ☐ No

Have you recovered from this disability?: ☐ Yes ☐ No If Yes, date you were able to return to work: ____ / ____ / _____

Have you since worked for wages or profit?: ☐ Yes ☐ No If Yes, list dates: _____

9. Name of last employer prior to disability. If more than one employer in previous eight (8) weeks, name all employers. Average Weekly Wage is based on all wages earned in last eight (8) weeks worked.

LAST EMPLOYER(S) PRIOR TO DISABILITY			PERIOD OF EMPLOYMENT		
Firm or Trade Name	**Address**	**Phone Number**	**First Day** (MM/DD/YYYY)	**Last Day Worked** (MM/DD/YYYY)	**Average Weekly Wage** (Include Bonuses, Tips, Commissions, Reasonable Value of Board, Rent, etc.)
					$0.00
					$0.00

Enter total wages earned in the last 8 weeks prior to the first day of disability below (Include wages for all employers listed above)

Week No.	Last Day Worked (MM/DD/YYYY)	No. of Days Worked	Gross Amount Paid
1			$0.00
2			$0.00
3			$0.00
4			$0.00
5			$0.00
6			$0.00
7			$0.00
8			$0.00
		Calculated average gross weekly wage:	$0.00

10. My job is or was: _____ (Occupation) 11. Union Member: ☐ Yes ☐ No If "Yes": _____ (Name of Union or Local Number)

12. Were you claiming or receiving unemployment prior to this disability? ☐ Yes ☐ No

If you did **not** claim or if you claimed but did **not** receive unemployment insurance benefits *after* LAST DAY WORKED, explain reasons fully: _____

_____

If you did receive unemployment benefits, provide all periods collected: _____

_____

DB-450 10-23

PART A - CLAIMANT'S INFORMATION (Please Print or Type)

Name: _____ Social Security Number: _____

13. For the period of disability covered by this claim:
   A. Are you receiving wages, salary or separation pay? Yes ☐ No ☐
   B. Are you receiving or claiming:
      1. Unemployment Benefits? ☐Yes ☐ No 2. Paid Family Leave? ☐Yes ☐ No
      3. Workers' compensation for work-connected disability? ☐Yes ☐ No
      4. No-Fault motor vehicle accident? ☐ Yes ☐No **or** personal injury involving third party? ☐ Yes ☐ No
      5. Long-term disability benefits under the Federal Social Security Act for *this* disability? ☐Yes ☐No

IF "YES" IS CHECKED IN ANY OF THE ITEMS IN 13, COMPLETE THE FOLLOWING:

I have: ☐received ☐claimed from:_____for the period: ____ / ____ / _____ to: ____ / ____ / _____

2. In the year (52 weeks) before your disability began, have you received disability benefits for other periods of disability? ☐Yes ☐ No
   If yes, Paid by:_____from: ____ / ____ / _____ to: ____ / ____ / _____
3. In the year (52 weeks) before your disability began, have you received Paid Family Leave? ☐ Yes ☐ No
   If yes, Paid by:_____from: ____ / ____ / _____ to: ____ / ____ / _____
4. If you became disabled while employed or within four weeks of your last day worked, did your employer provide you with your rights under Disability Law within 5 days of your notice or request for disability forms? ☐ Yes ☐No

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I hereby claim Disability Benefits and certify that for the period covered by this claim I was disabled. I have read the instructions of this form and certify that the foregoing statements, including any accompanying statements are, to the best of my knowledge, true and complete.

_____ _____
Claimant's Signature **Date**

An individual may sign on behalf of the claimant only if they are legally authorized to do so and the claimant is a minor, mentally incompetent or incapacitated. If signed by other than claimant, print information below and complete and submit Form OC-110A, Claimant's Authorization to Disclose Workers' Compensation Records.

_____ _____ _____
On behalf of Claimant **Address** **Relationship to Claimant**

PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY. THE ATTENDING HEALTH CARE PROVIDER SHALL COMPLETE AND RETURN TO THE CLAIMANT WITHIN SEVEN (7) DAYS OF RECEIPT OF THIS FORM. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date in item 7-e. **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS**.

1. Last Name: _____ First Name: _____ MI: __
2. Gender: ☐ M ☐F ☐ X 3. Date of Birth: ___ / ___ / _____
4. Diagnosis/Analysis: _____ Diagnosis Code: _____
   a. Claimant's symptoms: _____
   b. Objective findings: _____
5. Claimant hospitalized?: ☐Yes ☐No From:____/____/_____To:____/____/ _____
6. Operation indicated?: ☐Yes ☐No a. Type _____ b. Date ____ / ____ / _____

7. ENTER DATES FOR THE FOLLOWING	MONTH	DAY	YEAR
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 because of this disability			
d. Date Claimant will again be able to perform work (Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)			
e. If pregnancy related, please check box and enter the date ☐estimated delivery date OR ☐ actual delivery date			

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease?:
   ☐ Yes ☐No If "Yes", has medical been filed with the Board? ☐ Yes ☐No

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I certify that I am a:

_____ _____ _____
(Physician, Chiropractor, Dentist, Podiatrist, Psychologist, Nurse-Midwife) **Licensed or Certified in the State of** **License Number**

_____ _____ _____
Health Care Provider's Printed Name **Health Care Provider's Signature** **Date**

_____ _____
Health Care Provider's Address **Phone #**

PART C - EMPLOYER INFORMATION (to be completed by the employer)

Employee Name: _____ **Social Security Number:** _____

1. Business's full legal name and mailing address

Business Name _____

Mailing Address _____

City, State _____

Zip Code _____

Country (if not U.S.A.) _____

2. Employer's FEIN: _____

3. Contact Information:

Employer's contact name for questions relating to disability: _____

Employer's contact telephone number: _____

Employer's contact email address: _____

4. Is the employee a member of a union that provides the statutory disability benefits? ☐ Yes ☐ No

*If yes, provide Union name, address, and contact information _____

5. Employee Information:

Employee's role: ☐ Employee ☐ Proprietor ☐ Partner ☐ Spouse of Employer ☐ Owner ☐ Co-Owner

Employee's date of hire (MM/DD/YYYY): _____

Date employee last worked: _____

Date employee returned to work (if applicable): _____

6. Were wages continued during disability? ☐ Yes ☐ No

If yes, what type? (PTO, sick time, other): _____

If yes, is reimbursement requested by employer? ☐ Yes ☐ No

*Reimbursement is only available if employer continued salary during disability or employee used sick time

7. Is the employee's disability work-related? ☐ Yes ☐ No

8. Enter the last 8 weeks of gross wages for the employee immediately prior to the disability starting with the week the disability began, and calculate the average gross weekly wage (include bonuses, tips, commissions, reasonable value of board, rent, etc. and see instructions for more information)

Week No.	Week ending date (MM/DD/YYYY)	No. of days worked	Gross amount paid
1			$0.00
2			$0.00
3			$0.00
4			$0.00
5			$0.00
6			$0.00
7			$0.00
8			$0.00
		Calculated average gross weekly wage:	$0.00

9. In the preceding 52 weeks has the employee taken leave for:

☐ NYS Disability ☐ PFL ☐ Both Disability and PFL ☐ None

Disability: Please provide specific dates for disability _____

PFL: Please provide specific dates for PFL _____

10. Is employee still in your employment? ☐ Yes ☐ No

If no, date employment was terminated _____

PART C - EMPLOYER INFORMATION (to be completed by the employer)

Employee Name: _____ Social Security Number: _____

11. If employee received unemployment benefits, date the benefit was last received:_____

12. Employee's normal work schedule: ☐ M ☐ T ☐ W ☐ Th ☐ Fri ☐ Sat ☐ Sun

I have read and acknowledge the fraud information below and affirm that to the best of my knowledge and belief, the information I have provided is true and accurate.

Employer Name and Title: _____

Employer Signature: _____

Employer Contact Phone Number: _____

Date: _____

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a). The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law

HIPAA NOTICE - In order to adjudicate a workers' compensation claim or disability benefits claim, WCL 13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the insurance carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

Disclosure of Information: The Board will not disclose any information about your case to any unauthorized party without your consent. If you choose to have such information disclosed to an unauthorized party, you must file with the Board an original signed Form OC-110A "Claimants Authorization to Disclose Workers' Compensation Records." This form is available on the WCB website (www.wcb.ny.gov) and can be accessed by clicking the "Forms" link. If you do not have access to the internet please call (877) 632-4996. In lieu of Form OC-110A, you may also submit an original signed, notarized authorization letter.

FRAUD ACKNOWLEDGEMENT - An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

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

Claimant's Name: _____ Plan #_____	SOCIAL SECURITY NUMBER | |
STD 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 HRS	FREQUENTLY 2.5 – 5.5 DAILY HRS	CONTINUOUSLY 5.5 – 8 DAILY HRS
SIT	☐	☐	☐	☐
STAND	☐	☐	☐	☐
LIFT/CARRY	INDICATE AMOUNT/FREQUENCY BELOW			
0-10 LBS	☐	☐	☐	☐
10-20 LBS	☐	☐	☐	☐
20-50 LBS	☐	☐	☐	☐
50-100 LBS	☐	☐	☐	☐
OVER 100 LBS	☐	☐	☐	☐

	NEVER	OCCASIONALLY .25 – 2.5 DAILY HRS	FREQUENTLY 2.5 – 5.5 DAILY HRS	CONTINUOUSLY 5.5 – 8 DAILY HRS
WALK	☐	☐	☐	☐
DRIVE	☐	☐	☐	☐
REACH ABOVE	☐	☐	☐	☐
BEND/STOOP	☐	☐	☐	☐
USE HANDS FOR	INDICATE ACTIVITY/FREQUENCY BELOW			
PUSHING/PULLING	☐	☐	☐	☐
FINE MANIPULATION	☐	☐	☐	☐
STRESS LEVEL	☐ LOW	☐ MODERATE	☐ HIGH	☐ VERY HIGH

Employer Name / Division # _____ **I CERTIFY THE INFORMATION ABOVE IS CORRECT**

Address _____ Signed _____ Date_____

City, State, Zip_____ Print or Type Name _____

Federal EIN: _____ Official Title_____

Guardian

Direct Pay Enrollment and Authorization

If you are unable to provide a handwritten signature due to technical limitations resulting from the COVID-19 pandemic, Guardian will accept a typewritten name in lieu of your signature on an interim basis. 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.

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 State Disability Claims
PO Box 14332, Lexington KY 40512

To fax the form:
(610)-807- 2953

For direct deposit of your State Disability (SMD) benefit payments to your checking or savings account, please include all of the information requested. Please allow up to 10 business days for processing, upon receipt of completed documentation. If you have any questions about completing this form, please contact us at (800) 268-2525.
** **Please be advised that not all SMD plans are subject to direct deposit availability** **

1. Claim Information Required fields:

Claimant Name: Group #: Claim Number (if known):

2. REQUIRED:

Account Type:

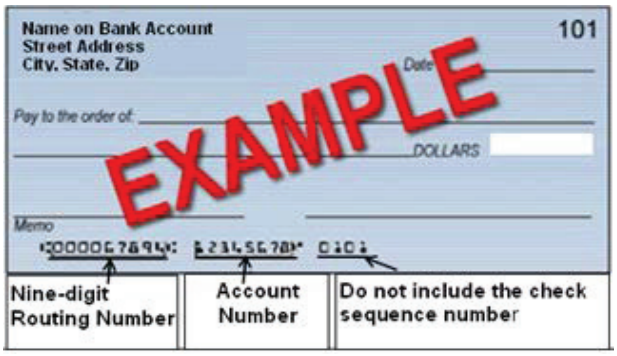
☐ Checking Account **or** ☐ Savings Account

Bank Name:

Bank Routing Number (ABA#):

Bank Account Number:

**Required Information*



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. **This request will also stay in effect should my SMD claim transition into an approved LTD claim, if applicable**. I understand that I have the opportunity to view my EOBs and payment history via registration on GuardianAnytime.com.

☐ Check this box to discontinue receiving paper EOBs.

_____ _____
Claimant Signature Date

☐ 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.

4. Joint Account Holder Agreement (Please check here if you are the sole account holder) ☐

I understand and agree that any funds deposited after the date of death of the Claimant that are not otherwise payable under the plan are to be immediately returned to Guardian Life Insurance Company of America.

_____ _____
Joint Account Holder Signature Date

☐ 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.