GUARDIAN® The Guardian Life Insurance Company of America

Group STD Claims
P.O. Box 14331
Lexington, KY 40512

Direct Pay Enrollment and Authorization

For direct deposit of your Short Term Disability (STD) 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 STD plans are subject to direct deposit availability** **

1. Claim Information:

Claim Number (if known): _____ Claimant Name*: _____ Group #*: 00528683

2. Provide the following bank information*:

Account Type:

☐ Checking Account
(include a blank personal check marked "void" or a letter from your financial institution with the routing and account numbers) *See the check diagram to the right to identify the bank routing number and your account number*

or

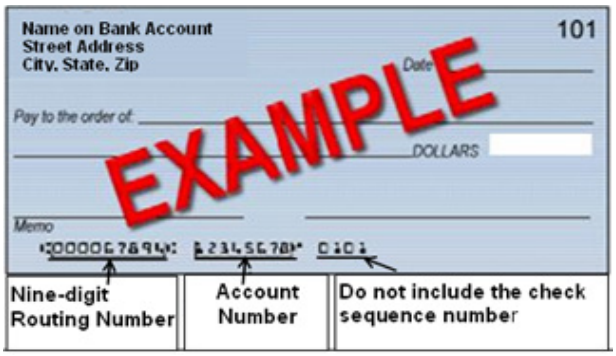
☐ Savings Account
(include a copy of a bank deposit slip with account number & routing number or a letter from your bank with this required information)

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 STD 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

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

5. Please use either method below to return the completed authorization and any attachments (if applicable):

Electronic Submission (FOR FASTEST PROCESSING):

www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.

Fax: 610-807-8270

Mail: Guardian Life Insurance Company of America
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