



## 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 Short Term Disability Claims  
PO Box 14331, Lexington KY 40512

**To fax the form:**

(610)-807-8270

**Customer Service:**

1-800-268-2525

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 #: \_\_\_\_\_

### 2. Required

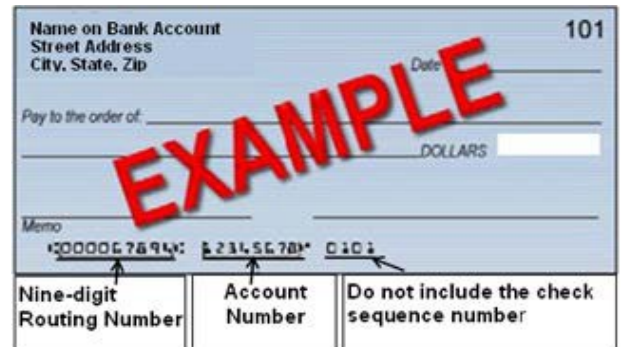
**Account Type: (Choose One)**

Checking Account      or      Savings Account

Bank Name: \_\_\_\_\_

Bank Routing Number (ABA#): \_\_\_\_\_

Bank Account 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. **This request will also stay in effect should my STD claim transition into an approved STD 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

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### 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

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