Guardian®

Family Medical Leave Request Form

To submit a new leave request, please complete and fax or email this form to 469-535-2415 or FML_Leave_Team@glic.com.
The Employee and Employer sections can be completed separately, but need to be submitted together.

EMPLOYEE SECTION - PLEASE PRINT AND COMPLETE IN FULL TO PREVENT DELAY IN PROCESSING

1. EMPLOYEE NAME

2. EMPLOYER NAME

3. EMPLOYER GROUP ID NUMBER

4. EMPLOYEE HOME MAILING ADDRESS CITY STATE ZIP

5. EMPLOYEE TELEPHONE NUMBER
(H) (_____) _____-_____
(W) (_____) _____-_____

6. EMPLOYEE WORK EMAIL ADDRESS

7. EMPLOYEE PERSONAL EMAIL ADDRESS

8. DATE OF BIRTH _____ /_____ /_____

9. SOCIAL SECURITY NUMBER _____ - _____ - _____

10. ☐ MALE ☐ FEMALE

11. PREFERENCE FOR RECEIVING FML DOCUMENTS ☐ MAIL ☐ PERSONAL EMAIL ☐ WORK EMAIL ☐ ALL

LEAVE REQUEST SECTION – PLEASE COMPLETE IN FULL TO PREVENT DELAY IN PROCESSING

12. SELECT LEAVE REASON
☐ EMPLOYEE HEALTH CONDITION ☐ FAMILY HEALTH CONDITION ☐ PREGNANCY/MATERNITY ☐ CARE FOR NEWBORN (BABY BONDING) ☐ ADOPTION ☐ FOSTER CARE
☐ FAMILY INJURED SERVICE MEMBER ☐ FAMILY INJURED VETERAN ☐ FAMILY MILITARY EXIGENCY ☐ OTHER _____

IF LEAVE REASON IS EMPLOYEE HEALTH CONDITION - COMPLETE 13-17 BELOW

13. IS DISABILITY DUE TO YOUR EMPLOYMENT? ☐ YES ☐ NO
IF "YES", HAVE YOU FILED A WORKERS' COMPENSATION CLAIM? ☐ YES ☐ NO

14. IS DISABILITY DUE TO AN ACCIDENT? ☐ YES ☐ NO

15. IS SURGERY SCHEDULED? ☐ YES ☐ NO ☐ N/A SURGERY DATE _____ /_____ /_____

16. BRIEF DESCRIPTION OF ILLNESS, INJURY OR CONDITION

17. ARE YOU ELIGIBLE TO RECEIVE ANY OTHER INCOME (SOCIAL SECURITY, WORKERS' COMPENSATION, STATE DISABILITY, PENSION, NO-FAULT, ASSOCIATION/INDIVIDUAL DISABILITY PLANS AND SALARY CONTINUATION AND/OR SICK LEAVE BENEFITS, ETC.)? ☐ YES ☐ NO IF "YES", ATTACH A COPY OF THE AWARD LETTER OR SUPPLY TYPE OF BENEFITS, AMOUNT, FREQUENCY, TELEPHONE NUMBER, AND IDENTIFICATION NUMBER OF SOURCE (ATTACH A SEPARATE PAPER IF NEEDED)

IF LEAVE REASON IS PREGNANCY/MATERNITY - COMPLETE 18-22 BELOW

18. PLEASE INDICATE TYPE OF DELIVERY ☐ VAGINAL ☐ C-SECTION

19. DATE OF BIRTH
ESTIMATED _____ /_____ /_____ (IF UNDELIVERED)
ACTUAL _____ /_____ /_____

20. MULTIPLE BIRTHS? ☐ YES ☐ NO

21. CHILD'S GENDER ☐ MALE ☐ FEMALE

22. PREGNANCY COMPLICATIONS DESCRIPTION - IF APPLICABLE

IF LEAVE REASON IS EMPLOYEE HEALTH OR PREGNANCY - COMPLETE 23 BELOW

23. IF YOUR REQUEST FOR SHORT TERM DISABILITY IS **APPROVED** AND YOUR BENEFIT IS TAXABLE, PLEASE GIVE AMOUNT YOU WANT US TO WITHHOLD **PER WEEK** FOR FEDERAL INCOME TAX (MUST BE WHOLE DOLLAR AMOUNT OF AT LEAST $20 PER WEEK AND MAY NOT REDUCE BENEFIT TO LESS THAN $10). **$**_____ **OR** _____**%**

PLEASE NOTE: CERTAIN DISABILITY BENEFITS ARE CONSIDERED SUPPLEMENTAL WAGES BY THE IRS (SEE IRS PUBLICATION 15A). IF YOUR DISABILITY BENEFIT IS DETERMINED TO MEET THESE REQUIREMENTS, A MANDATORY FEDERAL INCOME TAX WITHHOLDING (22%) IS REQUIRED. IF YOUR CLAIM IS PAYABLE, GUARDIAN WILL ADVISE YOU AT TIME OF PAYMENT IF THIS MANDATORY WITHHOLDING APPLIES TO YOUR BENEFIT PAYMENTS.

IF LEAVE REASON IS FOR A FAMILY MEMBER - COMPLETE 24-28 BELOW

24. FAMILY MEMBER'S NAME

25. FAMILY MEMBER'S DATE OF BIRTH _____ /_____ /_____

26. ☐ MALE ☐ FEMALE

27. RELATIONSHIP TO EMPLOYEE
☐ CHILD ☐ PARENT ☐ SPOUSE ☐ DOMESTIC PARTNER ☐ SIBLING ☐ AUNT ☐ UNCLE ☐ COUSIN ☐ FIANCE
☐ GRANDPARENT ☐ GRANDCHILD ☐ NEPHEW ☐ NIECE ☐ OTHER _____

28. RELATIONSHIP ATTRIBUTE ☐ BIOLOGICAL ☐ STEP ☐ IN-LAW ☐ OTHER _____

MISSED WORK SECTION - COMPLETE 29-34 BELOW

29. LAST DAY WORKED _____ /_____ /_____

30. LEAVE START DATE _____ /_____ /_____

31. ANTICIPATED END DATE _____ /_____ /_____ OR ANTICIPATED WEEKS OF LEAVE _____ WEEKS

32. LEAVE TYPE ☐ CONTINUOUS LEAVE ☐ INTERMITTENT LEAVE ☐ REDUCED SCHEDULE LEAVE

33. RETURN TO WORK DATE ☐ ACTUAL _____ /_____ /_____ ☐ ESTIMATED

34. IF REDUCED SCHEDULE LEAVE _____ HOURS MISSED/WEEK _____ HOURS MISSED/DAY

PHYSICIAN INFORMATION

35. PRINTED NAME OF PHYSICIAN _____ SPECIALTY _____

PRINTED ADDRESS OF PHYSICIAN _____ TELEPHONE NUMBER (_____) _____-_____

FAX NUMBER (_____) _____-_____ EMAIL ADDRESS _____

FOR QUESTIONS REGARDING THE LEAVE REQUEST, CONTACT GUARDIAN AT 1-888-889-2953.

END OF EMPLOYEE SECTION

THE FORM SHOULD BE SUBMITTED BY FAX OR EMAIL ALONG WITH THE COMPLETED EMPLOYER SECTION ON THE FOLLOWING PAGE

EMPLOYER SECTION ï PLEASE PRINT AND COMPLETE IN FULL (QUESTIONS 1-21) TO PREVENT DELAY IN PROCESSING

1. EMPLOYER NAME | 2. PLAN NUMBER

3. EMPLOYER ADDRESS | CITY | STATE | ZIP

4. IF BRANCH OR AFFILIATE, PLEASE PROVIDE NAME OF PARENT COMPANY | 5. DATE EMPLOYEE TERMINATED/RESIGNED (IF APPLICABLE)

6. EMPLOYEE NAME | 7. EMPLOYEE SOCIAL SECURITY NUMBER _____ - _____ - _____ | 8. EMPLOYEE DATE OF BIRTH _____ /_____ /_____

9. EMPLOYEE JOB TITLE | 10. DATE OF EMPLOYMENT _____ /_____ /_____ | 11. IS EMPLOYEE TEMP OR REHIRE? ☐ TEMP ☐ REHIRE | 12. REHIRE DATE _____ /_____ /_____

13. ADJUSTED SERVICE DATE _____ /_____ /_____

14. NORMAL WORK SCHEDULE: MON ☐ TUES ☐ WED ☐ THURS ☐ FRI ☐ SAT ☐ SUN ☐ _____ HOURS/WEEK _____ HOURS/DAY

15. ACTUAL LAST DAY WORKED _____ /_____ /_____ | 16. HOURS WORKED ON LAST DAY | 17. EMPLOYEE'S WORK STATE | 18. DOES EMPLOYEE'S WORK LOCATION MEET THE FMLA 50/75 RULE? ☐ YES ☐ NO ☐ N/A | 19. HOURS WORKED IN PAST 12 MONTHS

20. EMPLOYEE'S HR CONTACT | NAME | EMAIL | PHONE NUMBER (_____) _____-_____

21. EMPLOYEE'S SUPERVISOR | NAME | EMAIL | PHONE NUMBER (_____) _____-_____

IF THE REQUEST IS FOR THE EMPLOYEE'S OWN HEALTH CONDITION - COMPLETE 22-29 BELOW

22. A) DID THIS EVENT ARISE OUT OF EMPLOYMENT? ☐ YES ☐ NO IF "YES", PLEASE EXPLAIN

B) HAS A WORKERS' COMPENSATION CLAIM BEEN FILED? ☐ YES ☐ NO

23. DID THE EMPLOYEE ELECT STD COVERAGE? IF YES, PLEASE PROVIDE THE EFFECTIVE DATE. ☐ YES ☐ NO ☐ N/A _____ /_____ /_____

24. EMPLOYEE INSURANCE CLASS _____

25. DATE EMPLOYEE RETURNED TO WORK (IF APPLICABLE) ☐ PART TIME ☐ FULL TIME _____ /_____ /_____

26. VOCATIONAL ASSISTANCE IS AVAILABLE TO ASSIST IN RETURNING THE EMPLOYEE TO WORK. FOR VOCATIONAL ASSISTANCE CALL 800-233-0691 OR PROVIDE THE PERSON GUARIDAN SHOULD CONTACT.
NAME:_____ PHONE: (_____) _____-_____

27. SALARY – PLEASE PROVIDE: ☐ HOURLY ☐ WEEKLY ☐ BI-WEEKLY ☐ SEMI-MONTHLY ☐ MONTHLY ☐ YEARLY
NOTE: IF WORK STATE IS NY, PLEASE PROVIDE EMPLOYEE'S 8 WEEK SALARY ON THE NY PFL SUPPLEMENTAL FORM.

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: _____ /_____ /_____

IF EARNINGS DEFINITION BASES SALARY ON PRIOR YEAR W-2, PLEASE ATTACH A COPY OF THE PRIOR YEAR W-2 (IF EMPLOYED IN PRIOR YEAR) OR PROVIDE YEAR-TO-DATE SALARY: $_____ FROM _____ /_____ /_____ TO _____ /_____ /_____

28. DOES THE EMPLOYEE CONTRIBUTE TO THE COST OF THEIR SHORT TERM DISABILITY INSURANCE PREMIUM? ☐ YES ☐ NO

IF "YES", PLEASE BE SURE TO COMPLETE THE FOLLOWING ACCURATELY AND FULLY _____% 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.

29. **JOB DESCRIPTION ï PLEASE FULLY COMPLETE THE BELOW DETAILS ABOUT THE PHYSICAL ASPECTS OF THE EMPLOYEE'S JOB DURING A NORMAL SHIFT**

	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	☐	☐	☐	☐

PLEASE ATTACH A COPY OF THE EMPLOYEE'S JOB DESCRIPTION, IF AVAILABLE.

30. 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 (_____) _____-_____ EMAIL ADDRESS _____

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END OF EMPLOYER SECTION

THE FORM SHOULD BE SUBMITTED BY FAX OR EMAIL ALONG WITH THE COMPLETED EMPLOYEE SECTION ON THE PREVIOUS PAGE

Guardian®

Authorization to Obtain Information
(Medical records and other information)

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

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 authorized representative) Relationship Date

Name of Insured _____

Address _____

Claim # _____ Policy # _____ Date of Birth _____

Fraud Warning Statements

The laws of several states require the following statements to appear on the authorization 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.

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, Kansas, Nebraska, Oregon, and Vermont: 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.

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, Virginia 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 guilty 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.

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.