



State Disability TeleGuard® Claim Submission Instructions and Authorization

Employer/Plan holder Name

Clyde Companies

Employer/ Plan Number

894859

Your employer has chosen to offer you State Disability coverage through Guardian. Since any disability can cause challenges, we have made filing a claim easy. You can simply call to file a claim.

This document includes two very important sections.

Section One, **How to File Your Disability Claim**, explains how to file your claim, as well as provide you with some basic information that will be discussed during your call to begin your claim.

Section Two, **Authorization to Obtain Information**, is very important to enabling Guardian to obtain the needed medical information in support of your claim of disability.

Section One: How to File Your Disability Claim

To file your disability claim, please call 1-888-262-5670 as soon as your disability begins. A Guardian Claim Intake Specialist can be reached Monday through Friday, between the hours of 8:00 am – 8:00 pm (EST). The Intake Specialist will guide you through the claim filing process and be able to assist you with understanding the next steps. Please be prepared to provide the following information:

- 1 Your full name, address, phone number and social security number
- 2 Your Guardian 6-digit plan number
- 3 Your Employer contact name and phone number
- 4 Your physician's name, specialty, address, phone number, and fax number
- 5 The nature of your disability, including diagnosis, surgical procedures, next appointment and any actual or estimated return to work dates

Section Two: Authorization to Obtain Information

Attached to this page is an authorization that you will need to complete and provide to the treatment provider(s) who have determined that you are unable to fully perform your job duties. It is extremely important that your signed authorization is in your treatment provider's/physician's possession at the time a Guardian Representative contacts them by phone to obtain the needed medical information. We also encourage you to advise your treatment provider to expect a call from a Guardian Representative and that you give your consent to the release of the needed medical information. Your treatment provider/physician may also require you to complete their own (internal) authorization.

Please advise your treatment provider that their unwillingness to supply this information when contacted by Guardian could result in a delay in Guardian reaching a decision on your claim.

After your claim is filed, you can obtain ongoing claim status by calling Guardian at 1-800-268-2525. You can also visit www.guardiananytime.com to file a claim.

Authorization to Obtain Information (Medical records and other information)

Important

Please supply this completed authorization to your Treatment Provider and advise them that a Guardian Representative will be contacting them by phone to obtain medical information that is needed to make a decision on your Group Disability Claim. Please also advise them that their failure to supply the needed medical information could cause a delay Guardian in being able to make a decision on your claim.

This Authorization Is Designed To Comply With The HIPAA Privacy Rule

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." Should you wish to obtain the specific fraud language for your state, you may contact your State's Insurance Commissioner's office.

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. Electronic authorization of this document will be equally as effective and valid as if signed through traditional means. I understand, however, that I am under no obligation to sign this document electronically.

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 of 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.