GUARDIAN®

STD & Leave Instructions
Guardian AbsenceWorks®

G-00387411

Liberty Utilities

IMPORTANT INSTRUCTIONS FOR LEAVE OF ABSENCES/STD FILING

To avoid delays in processing, prior to initiating your claim, please inform your physician that a Representative will be contacting their office to obtain medical information. Your assistance may help to expedite your claim review.
To expedite your claim filing process, call toll-free at 1-888-889-2953 to initiate your claim as soon as your disability/leave begins; please call Monday-Friday, 7:00 am to 7:00 pm, CST.
You may also initiate your leave on-line:https://g00387411.glicleavepro.com

Please be prepared to provide the following information:
1. Your name, social security number, address and telephone number;
2. Your physician's name, address, phone and fax numbers;
3. Please sign the authorization on the back and provide a copy to your treating physician(s).

After your claim has been initiated, for questions regarding ongoing claim status, you may call 1-888-889-2953.

The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY. 2014-14877

AUTHORIZATION - please read, sign and date below.

By my signature below, I authorize any physician, medical or mental health profession, practitioner, office, hospital, or other treatment facility to disclose all records and information pertaining to my health care, treatment, diagnostic testing, results, diagnoses, medication, and the like to The Guardian Life Insurance Company of America and its affiliates (collectively "Guardian"). I also specifically authorize Guardian to obtain information concerning my mental health, use of alcohol or drugs, or any disorders of the immune system including HIV or acquired immune deficiency (AIDS). I understand that this authorization is valid for a period of 24 months beginning with the date I sign this authorization, unless a shorter period is required by applicable law. I further acknowledge and consent that such information may be shared with Guardian's affiliates as necessary to administer my benefits.
Please retain your original authorization in the event that it is needed in the future.

_____
Employee Name - First, Last Name (please print)

_____ _____
Employee/Patient Signature Date

GG-017385