Guardian®

Group Short Term Disability Claim

To expedite your claim review, STD claims may be filed on-line by visiting us at www.guardiananytime.com.
Or, you may complete the form and submit by fax to (610) 807-8270 or email to group_std_claims@glic.com
You may also send to: Group STD Claims, P.O. Box 14331, Lexington, KY 40512 **Customer Service toll-free: 1-800-268-2525**

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

1. EMPLOYEE NAME | 2. PLAN NUMBER 412296 | 3. EMPLOYER NAME

4. EMPLOYEE HOME MAILING ADDRESS CITY STATE ZIP | 5. EMPLOYEE TELEPHONE NUMBER (_____) _____-_____

EMPLOYEE EMAIL ADDRESS

6. DATE OF BIRTH _____ /_____ /_____ | 7. SOCIAL SECURITY NUMBER _____ - _____ - _____ | 8. ☐ MALE ☐ FEMALE | 9. ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ LEGALLY SEPARATED ☐ DIVORCED | 10. NUMBER OF DEPENDENTS UNDER AGE 18 _____

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

12. IS DISABILITY DUE TO AN ACCIDENT? ☐ YES ☐ NO
IF "YES", DO YOU INTEND TO FILE SUIT? ☐ YES ☐ NO

13. IF YOU ANSWERED "YES" TO QUESTION (11) AND/OR (12), PLEASE PROVIDE THE FOLLOWING
DATE OF ACCIDENT TIME PLACE
ACCIDENT DETAILS

14. DATE SYMPTOMS FIRST APPEARED _____ /_____ /_____

15. RETURN TO WORK DATE ☐ ACTUAL _____ /_____ /_____ ☐ POSSIBLE

16. 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)

17. 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 (28%) IS REQUIRED. IF YOUR CLAIM IS PAYABLE, GUARDIAN WILL ADVISE YOU AT TIME OF PAYMENT IF THIS MANDATORY WITHHOLDING APPLIES TO YOUR BENEFIT PAYMENTS.

18. 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. In New York, the person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

"Please Note: Your Social Security number is required for IRS tax reporting purposes. Your Social Security number will not be used or disclosed to anyone for any other purpose and will not be retained in any record other than that pertaining to the claim."

PLEASE NOTE: THE ATTACHED HIPAA AUTHORIZATION MUST BE COMPLETED

SIGNATURE OF EMPLOYEE _____ DATE _____

PHYSICIAN SECTION – PLEASE COMPLETE IN FULL AND RETURN TO PREVENT DELAY IN PROCESSING

1. DIAGNOSIS(ES) | 2. ICD-10 CODE(S)

3. IS PATIENT'S DISABILITY DUE TO A) EMPLOYMENT ☐ YES ☐ NO B) ACCIDENT ☐ YES ☐ NO C) PREGNANCY ☐ YES ☐ NO

4. IF DISABILITY IS DUE TO PREGNANCY, PLEASE INDICATE DATE OF DELIVERY ESTIMATED _____ /_____ /_____ (IF UNDELIVERED)
PLEASE INDICATE TYPE OF DELIVERY ☐ VAGINAL ☐ C-SECTION ☐ MULTIPLE BIRTHS ACTUAL _____ /_____ /_____

5. DATE SYMPTOMS FIRST APPEARED _____/_____/_____ | 6. DATE OF FIRST VISIT FOR THIS CONDITION _____ /_____ /_____ | 7. A) DATES OF TREATMENT FOR THIS CONDITION | 8. HEIGHT _____ WEIGHT _____ LBS

9. DATE PATIENT WAS TOTALLY DISABLED (UNABLE TO WORK)
FROM _____ /_____ /_____ THROUGH _____ /_____ /_____

7. B) DATE OF PATIENT'S NEXT APPOINTMENT _____ /_____ /_____

10. IF PATIENT STILL DISABLED, GIVE DATE FOR ANTICIPATED RELEASE TO RETURN TO WORK _____ /_____ /_____

11. DATES PATIENT WAS HOSPITALIZED (IF APPLICABLE)
FROM _____ /_____ /_____ THROUGH _____ /_____ /_____

12. SURGICAL DATE(S): _____
CPT(S)/PROCEDURE(S) _____

13. A) WOULD YOU SUPPORT THE PATIENTS RETURN TO WORK ON A LIMITED BASIS? ☐ YES ☐ NO
IF "YES", PLEASE PROVIDE RESTRICTIONS AND LIMITATIONS THAT WOULD BE IN PLACE

13. B) DURATION OF ABOVE RESTRICTIONS: _____

14. A) WAS PATIENT REFERRED TO YOU BY ANOTHER PHYSICIAN? ☐ YES ☐ NO
IF "YES", PLEASE GIVE NAME AND TELEPHONE NUMBER OF PHYSICIAN

14. B) DID YOU REFER PATIENT TO ANOTHER PHYSICIAN? ☐ YES ☐ NO
IF "YES", PLEASE GIVE NAME AND TELEPHONE NUMBER OF PHYSICIAN

15. DO YOU BELIEVE THE PATIENT IS COMPETENT TO ENDORSE CHECKS AND DIRECT THE PROCEEDS THEREOF? ☐ YES ☐ NO

16. PRINTED NAME OF PHYSICIAN _____ SPECIALTY _____

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

FAX NUMBER (_____) _____-_____ EMAIL ADDRESS _____ TAX ID # _____

SIGNATURE OF PHYSICIAN _____ DATE _____

You may file STD claims online, and check claim status by visiting us at www.guardiananytime.com

EMPLOYER SECTION – PLEASE PRINT AND COMPLETE IN FULL (QUESTIONS 1-24) TO PREVENT DELAY IN PROCESSING

1. EMPLOYER NAME

2. PLAN NUMBER 412296

3. EMPLOYER ADDRESS CITY STATE ZIP

4. IF BRANCH OR AFFILIATE, PLEASE PROVIDE NAME OF PARENT COMPANY EMPLOYER SOCIAL SECURITY OR TAX ID

5. DATE EMPLOYEE TERMINATED/RESIGNED

6. EMPLOYEE NAME

7. EMPLOYEE SOCIAL SECURITY NUMBER _____ - _____ - _____

8. EMPLOYEE DATE OF BIRTH _____ /_____ /_____

9. EMPLOYEE JOB TITLE

10. DATE OF EMPLOYMENT _____/_____/_____

11. DATE EMPLOYEE EFFECTIVE FOR STD _____/_____/_____

12. EMPLOYEE INSURANCE CLASS _____

13. ACTUAL LAST DAY WORKED _____ /_____ /_____

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

15. HOURS WORKED ON LAST DAY

16. REASON FOR LEAVING WORK: ☐ DISABILITY ☐ **OTHER:** _____

17. CAN THE EMPLOYEE'S JOB BE MODIFIED TO ALLOW FOR RETURN TO WORK?
☐ YES ☐ NO ☐ MAYBE, DEPENDING ON RESTRICTIONS

18. DATE EMPLOYEE RETURNED TO WORK _____ /_____ /_____ ☐ PART TIME ☐ FULL TIME

19. SALARY – PLEASE PROVIDE: ☐ HOURLY ☐ WEEKLY ☐ BI-WEEKLY ☐ SEMI-MONTHLY ☐ MONTHLY ☐ YEARLY

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 _____ /_____ /_____

20. 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 28% FEDERAL INCOME TAX WITHHOLDING FROM THE DISABILITY BENEFIT CHECKS THAT ARE ISSUED.

21. FOR ASSISTANCE WITH JOB ACCOMMOCATION STAY AT WORK OPPORTUNITIES, CONTACT OUR VOCATIONAL REHABILITATION DEPT. AT 800-233-0691, OR, TO RECEIVE A CALL FROM OUR VOC REHAB DEPT., PLEASE PROVIDE US WITH THE PERSON YOU WOULD LIKE US TO CONTACT:

NAME:

PHONE:

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

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

23. **JOB DESCRIPTION** – **Please fully complete the following details about the physical aspects of the claimant's job as performed in an 8 hour work day. Please also attach a description of job duties, if available.**

	NEVER	OCCASIONALLY .25 – 2.5 DAILY HRS	FREQUENTLY 2.5 – 5.5 DAILY HRS	CONTINUOUSLY 5.5 – 8 DAILY HRS		NEVER	OCCASIONALLY .25 – 2.5 DAILY HRS	FREQUENTLY 2.5 – 5.5 DAILY HRS	CONTINUOUSLY 5.5 – 8 DAILY HRS
SIT					WALK				
STAND					DRIVE				
LIFT/CARRY	INDICATE AMOUNT/FREQUENCY BELOW				REACH ABOVE				
0-10 LBS					BEND/STOOP				
10-20 LBS					USE HANDS FOR	INDICATE ACTIVITY/FREQUENCY BELOW			
20-50 LBS					PUSHING/PULLING				
50-100 LBS					FINE MANIPULATION				
OVER 100 LBS					STRESS LEVEL ☐ LOW ☐ MODERATE ☐ HIGH ☐ VERY HIGH				

24. 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 _____

You may file STD claims online, and check claim status by visiting us at www.guardiananytime.com

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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 # 412296 Date of Birth _____

Fraud Warning Statements

The laws of several states require the following statements to appear on the claim 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, Nebraska and Oregon: 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.

Kansas: 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 insurance fraud as determined by a court of law.

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 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

Vermont: It is a crime for any person knowingly to provide material false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company, for any person knowingly to provide material false, incomplete, or misleading information concerning the sale of insurance or the status of an insurer, or for any person to misappropriate the funds of an insured or an applicant for insurance. Penalties include imprisonment, fines, and denial of insurance benefits.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Guardian

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 #: 412296

2. REQUIRED: Provide a voided check, deposit slip or letter from your financial institution with routing and account numbers and attach to this authorization request. See example.

Account Type: (Choose One)

☐ Checking Account or ☐ Savings Account

Bank Name:

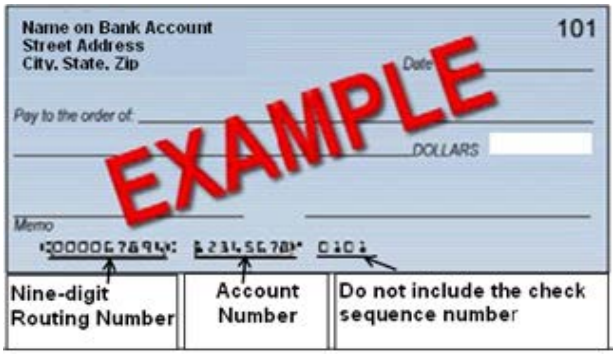
_____

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