GUARDIAN® The Guardian Life Insurance Company of America

Group Critical Illness Claim Form

Send to the Life Department Claim Office, Critical Illness Team, Box 26035, Lehigh Valley, PA 18002-6035
Secure E-mail: www.GuardianAnytime.com, click secure channel, select Group_Life_Claims@GuardianLife.com
Customer Service: (800) 268-2525 Fax: (610) 807-2999

EMPLOYER SECTION: To ensure privacy, please have the Employer section of the claim form completed first.

1. Planholder/Employer Name:
2. Plan Number:
3. Planholder/Employer Address: City State Zip
4. Telephone Number:
   Fax Number:
5. If branch or affiliate, name and relationship to parent company:
6. Name & address of branch where employee works:
7. Employee's Name:
8. Employee's Critical Illness Benefit:
9. Date of Birth:
10. Date of full time employment:
11. Insurance Class:
12. Schedule at time last worked:
    _____ hours per day
    _____ days per week
13. Employee's Date Last Worked:
14. Premiums Paid Through Date:
15. If insured with Guardian less than 24 months please provide:
    Prior Carrier Name: ______________________________________
    Employee Effective Date ________________
    Spouse Effective Date ________________
    Child Effective Date ________________
16. Date insurance effective under this plan:
    Employee ________________
    Spouse ________________
    Child ________________
17. Date employment terminated:
18. Contributions to the cost of this insurance:
    Does the employee contribute to the cost of their Critical Illness Benefit premium? ☐ Yes ☐ No
    If "Yes", please complete the following accurately:
    _____% paid by employer
    _____% paid by employee ☐ Pre-Tax ☐ Post-Tax
19. Remarks:
20. I certify that the employee named above has been a full-time, active employee for whom premiums have been paid.

Please Print Name: ____ Email Address: ____

Signature and Title: ____ Date: ___________________

EMPLOYEE SECTION **Indicate type of claim being submitted:** ☐ **Critical Illness** ☐ **Hospital Admission** ☐ **Wellness Benefit**

1. Employee's Name:
2. Plan Number:
3. Date of Birth:
4. Social Security #:
5. Gender: ☐ Male ☐ Female
6. Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated
7. Employee's Address:

   Employee email address, if available: ____
8. Home Telephone Number:
9. If this is a Critical Illness claim, please check applicable diagnosis:
   ☐ Cancer ☐ Coronary Artery Bypass Graft ☐ Heart Attack ☐ Kidney Failure
   ☐ Organ Transplant ☐ Stroke
10. Date of Critical Illness event:

11. Describe first symptoms of Critical Illness and date symptoms first appeared:

12. If this is a Hospital Admission Claim, please indicate dates of hospitalization, if applicable:

From _________________ To _________________

13. Is this claim for a Wellness Benefit?

☐ Yes ☐ No If "Yes", please attach supporting documentation.

14. Describe reason for hospital admission and date symptoms first appeared:

15. Claimant's date of death, if applicable:

16. Dependent's Name: (Complete if claim is for dependent only)

17. Dependent's Home Telephone Number:	18. Dependent Date of Birth:	19. Gender: ☐ Male ☐ Female	20. Marital Status: ☐ Single ☐ Married	21. Social Security Number:

22. Has the claimant ever had the same or similar condition in the past? ☐ Yes ☐ No Date of first treatment: _____ /_____ /_____
If "Yes", please provide names, addresses and telephone and fax numbers of physicians who first treated the claimant.

23. Name, complete address, telephone and fax numbers of family physician:

24. Names, complete addresses, telephone and fax numbers of physicians and hospitals that treated the claimant for this illness or injury:

25. I authorize any physician, medical practitioner, hospital, clinic, other health facility, consumer reporting agencies, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information about me in its possession to The Guardian Life Insurance Company of America or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding my medical history, mental or physical condition, or treatment. I understand that Guardian will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. Guardian will not release any information obtained to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be lawfully required or permitted, or as I may further authorize. I know that I may request and receive a copy of this authorization. I agree that a photocopy of this authorization shall be as valid as the original. I agree that this authorization shall be valid for the duration of my claim.

"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. In California, any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

"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."

____ _______________
Signature of Employee or Power of Attorney (attach Power of Attorney papers if applicable) Date

____ _______________
If a Dependent claim, Signature of Dependent or Power of Attorney (attach Power of Attorney papers if applicable) Date