



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

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? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", please complete the following accurately: _____ % paid by employer _____ % paid by employee <input type="checkbox"/> Pre-Tax <input type="checkbox"/> 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	6. Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> 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: <input type="checkbox"/> Cancer <input type="checkbox"/> Coronary Artery Bypass Graft <input type="checkbox"/> Heart Attack <input type="checkbox"/> Kidney Failure <input type="checkbox"/> Organ Transplant <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Male <input type="checkbox"/> Female	20. Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	21. Social Security Number:
22. Has the claimant ever had the same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> 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:				
<p>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.</p> <p>"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 <u>New York</u> 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."</p>				
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