



Group Critical Illness Claim Form

Send to the Life Department Claim Office, Critical Illness Team, PO Box 14334 Lexington KY 40512
Documents can be returned electronically at www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.

Customer Service: (800) 268-2525 Fax: (610) 807-2999

| | | | | | |
|---|---|--|---|--------------------------------|---|
| EMPLOYEE SECTION | | To avoid delays, please fill in the identifying claim information on each page. | | | |
| 1. Employee's Name: | | 2. Plan Number: 550470 | 3. Date of Birth: | 4. Social Security #: | |
| 5. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | 6. Marital Status: | 7. Mailing Address: Email address (optional): | | 8. Preferred Telephone Number: | |
| DEPENDENT SECTION | | COMPLETE THIS SECTION IF THE CLAIM IS FOR A DEPENDENT. | | | |
| 9. Dependent's Name: | | | 10. Dependent's Preferred Telephone Number: | | |
| 11. Date of Birth: | 12. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | 13. Marital Status: | 14. Social Security Number: | | |
| CLAIM INFORMATION SECTION | | | | | |
| 15. Please list the condition for which you are claiming a benefit (see page 2). | | | 16. On what date did the symptoms first appear? | | |
| If additional space is needed for questions 17-21, please attach a separate sheet of paper. | | | | | |
| 17. Please indicate name of hospital & dates of hospitalization, if applicable: Name of hospital: _____ Admitted: ___/___/___ Discharged: ___/___/___ | | | | | 18. Insured's date of death, if applicable: |
| 19. Name, complete address, telephone and fax numbers of family physician: | | | | | |
| 20. Names, complete addresses, telephone and fax numbers of physicians and hospitals that treated the insured for this illness or injury: | | | | | |
| 21. Has the insured ever had the same or similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No Dates of prior treatment: If yes, please provide names, addresses, telephone and fax numbers of physicians who previously treated the insured. | | | | | |
| 22. 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 <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." BEFORE SIGNING THIS CLAIM FORM, PLEASE READ THE WARNING FOR THE STATE WHERE YOU RESIDE AND FOR THE STATE WHERE THE INSURANCE POLICY UNDER WHICH YOU ARE CLAIMING A BENEFIT WAS ISSUED. "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 adult dependent or Power of Attorney (attach Power of Attorney papers if applicable) | | | | | Date |

PLEASE CHECK CONDITION FOR WHICH YOU ARE CLAIMING A BENEFIT.

Please attach pertinent medical records including but not limited to progress notes, test results, admit/discharge summaries and operative report. In addition, you may also include copies of insurance Explanation of Benefits and bills or receipts for services.

| CONDITION | CHILDHOOD CONDITIONS |
|--|---|
| <ul style="list-style-type: none"><input type="checkbox"/> Invasive Cancer<input type="checkbox"/> Cancer in Situ<input type="checkbox"/> Benign Brain Tumor<input type="checkbox"/> Skin Cancer<input type="checkbox"/> Cancer Vaccine<input type="checkbox"/> Coronary Artery Bypass Graft (CABG)<input type="checkbox"/> Heart Attack<input type="checkbox"/> Kidney Failure<input type="checkbox"/> Organ Transplant<input type="checkbox"/> Major Organ Failure<input type="checkbox"/> Heart Failure<input type="checkbox"/> Stroke (A completed MRS form from the physician is required. This can be found on Guardian Anytime/Forms.) <input type="checkbox"/> Coronary Arteriosclerosis<input type="checkbox"/> Addison's Disease<input type="checkbox"/> ALS (Lou Gehrig's Disease)<input type="checkbox"/> Alzheimer's<input type="checkbox"/> Coma<input type="checkbox"/> Huntington's Disease<input type="checkbox"/> Loss of Speech, Sight or Hearing<input type="checkbox"/> Multiple Sclerosis<input type="checkbox"/> Parkinson's Disease<input type="checkbox"/> Permanent Paralysis<input type="checkbox"/> Severe Burns | <ul style="list-style-type: none"><input type="checkbox"/> Cerebral Palsy<input type="checkbox"/> Cleft lip/palate<input type="checkbox"/> Club Foot<input type="checkbox"/> Cystic Fibrosis<input type="checkbox"/> Down's Syndrome<input type="checkbox"/> Muscular Dystrophy<input type="checkbox"/> Spina Bifida<input type="checkbox"/> Type 1 Diabetes |

Not all benefits may be available under your plan. Please refer to your certificate of coverage for specific benefits available under your plan.

Fraud Warning Statements

The laws of several states require the following statements to appear on the claim form, as a substitute for fraud warnings that appear in other areas of 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: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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 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 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.