Guardian®

Accidental Dismemberment & Catastrophic Loss Claim Form

If you are unable to provide a handwritten signature due to technical limitations resulting from the COVID-19 pandemic, Guardian will accept a type typewritten name in lieu of your signature on an interim basis. You must check the box below each signature line certifying that you understand that our typewritten name has the same force and effect as your signature.

For **faster** service please:
1. Complete this form on-line
2. Print, sign and scan it or use interim accommodation of typing your name in the signature line
3. Save the completed form to your computer
4. Upload via *Secure Channel*

To mail this form:
Guardian Group Life Claims
PO Box 14334, Lexington KY 40512
To fax the form:
(610)-807-8266
Customer Service:
1-800-525-4542

EMPLOYEE SECTION	**To be completed by employee or someone acting on behalf of the employee.**			
1. Employee's name				
2. Employee's address	City		State	Zip
3. Home telephone number ( ) -	4. Date of birth	☐ Male ☐ Female	☐ Single ☐ Married	5. Social Security No.
6. Dependent's name **(Complete if claim is for dependent)**				
7. Dependent's address	City		State	Zip
8. Home telephone number ( ) -	9. Date of birth	☐ Male ☐ Female	☐ Single ☐ Married	10. Social Security No.
11. Date of accident	12. On what date were you first treated by physician?			
13. Describe accident, giving all details in order of occurrence				
14. Name and address of all attending physicians:				

15. I authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager, other health facility, consumer reporting agency, 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 or claim, or as may be lawfully required or permitted, or as I may further authorize. I understand that any information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulation governing privacy. I have the right to cancel this authorization in writing at any time. 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 up to 24 months (12 months in Kansas).

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.

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.

Mode of payment: A check will be issued for any payable benefits.

"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 (Please attach Power of Attorney papers if applicable) Date

☐ **I am unable to provide a signature due to the COVID-19 pandemic. I understand that my typewritten name has the same force and effect as my signature.**

_____ _____

If a Dependent claim, signature of Dependent or POA (Please attach POA papers if applicable) Date

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EMPLOYER SECTION

Please enclose employee's original Enrollment Form along with any beneficiary changes.

1. Plan #	2. Planholder / Employer's name & address City State Zip	3. Telephone Number ( ) -

4. If branch or affiliate, name and relationship to parent company Claim Branch (if applicable)	5. Member ID

6. Job title at time last worked	7. Insurance class	8. Annual salary excluding bonus, overtime, and special compensation on the redetermination date of your plan $

9. Amount of AD&D insurance claimed: Basic: $_____ Voluntary: $ _____	10. Actual Last Day Worked	11. Schedule at time last worked _____ Hours per week

12. Date of employment	13. Date employee's insurance effective	14. Date returned to work	15. Date employment terminated

16. Did the injury arise out of employment? ☐ Yes ☐ No If "Yes", is claim being made for Worker's Compensation? ☐ Yes ☐ No Was the member travelling on company business at the time of the incident? ☐ Yes ☐ No Was the member's injury a result of a workplace assault? ☐ Yes ☐ No	17. Do you recommend payment of claim? ☐ Yes ☐ No

18. Date premium paid to:	19. Remarks

20. I certify that the employee named above has been a full-time, active employee for whom premiums have been paid.

Authorized signature	Print name	Title	Date

TO BE COMPLETED BY THE ATTENDING PHYSICIAN - Please submit medical treatment records, progress notes, results from all tests performed & operative report to support your diagnosis.

Name of Patient

1. Date you were first consulted on account of the injuries resulting from this accident

2. (a) Your diagnosis and date of amputation / loss

(b) Give a brief description of the injuries sustained

3. **Please check the appropriate loss (Please note: the insured should review their contract to see if it covers the claimed loss.)**

☐ hand at or above the wrist? ☐ Yes ☐ No ☐ thumb & index finger of same hand ☐ Yes ☐ No
☐ four fingers of same hand? ☐ Yes ☐ No
☐ all toes of same foot? ☐ Yes ☐ No ☐ great toe (hallux)? ☐ Yes ☐ No
☐ leg at or above the knee? ☐ Yes ☐ No
☐ arm at or above the elbow? ☐ Yes ☐ No
☐ foot at or above the ankle? ☐ Yes ☐ No
☐ 3rd degree burns covering 50-74% of the body? ☐ Yes ☐ No
☐ 3rd degree burns covering 75% or more of the body? ☐ Yes ☐ No ☐ Comatose state in excess of 1 month
☐ Quadriplegia ☐ Hemiplegia ☐ Paraplegia ☐ Uniplegia
☐ Loss of speech & hearing (both ears) ☐ Loss of speech ☐ Loss of hearing (both ears)
☐ Loss of cognitive function (Loss of cognitive function means a significant decline or loss in intellectual aptitude.)

To be completed if accident resulted in total and permanent loss of sight.
Please submit medical treatment records, progress notes, results from all tests performed & operative report to support your diagnosis.

4. Did the accident result in the loss of ☐ sight of right eye ☐ sight of left eye? Is the loss entire and irrecoverable? ☐ Yes ☐ No If not totally blind, what was vision at last observation? What is the extent of any gross visual field defect? O.D. _____ O.S. ____ Date:_____ O.D. _____ O.S. ____ Date:_____	Can vision be improved by treatment, operation, or lenses? ☐ Yes ☐ No If sight can be restored in either eye please give details:

5. Name and address of Hospital / Nursing Home: _____

_____

Phone number: _____ Fax number: _____

6. *If the injuries were not due to the accident stated above, please give details of any condition or disease which in your opinion may have served as a contributory cause*

7. Signature of Attending Physician	Print name

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8. Address

Phone number	Fax number	Email address	Date
_____	_____	_____	_____

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.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arkansas, West Virginia: 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 fines and confinement in prison.

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 false or fraudulent information to obtain or amend insurance coverage or to make a 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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

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.

New York: 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 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.

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: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.