



Send to Guardian Life Insurance, Accident Claims, PO Box 14315, Lexington, KY 40512
 Customer Service: 1-800-541-7846 Fax: (920) 749-6299
 Documents can be returned electronically at www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.

EMPLOYEE INFORMATION		
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:		7. Employee's Address:
8. Employee email address (optional):		9. Preferred Telephone Number:
DEPENDENT INFORMATION		
Complete this section, if the claim is for a dependent. Otherwise, proceed to the claim information section.		
10. Dependent's Name:		11. Dependent's Preferred Telephone Number:
12. Dependent's Date of Birth:		13. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
14. Relationship to the employee:		15. Dependent's Social Security Number:
<input type="checkbox"/> FIRST CLAIM <input type="checkbox"/> CONTINUED CLAIM <input type="checkbox"/> ACCIDENT <input type="checkbox"/> HOSPITAL CONFINEMENT (SICKNESS) *Separate Rider Required		
CLAIM INFORMATION SECTION		
If you have incurred an accident, please check the box or boxes that best describe your current Accident Claim. Attach any documentation you may have indicating the provider, patient's name, copy of itemized billing statement, date of service and if filing for the fracture benefit, a copy of the radiology report.		
<input type="checkbox"/> Fracture (Bone)/Dislocation/Surgery <input type="checkbox"/> Hospital Admission/Confinement (Accident) <input type="checkbox"/> Medical Expenses <input type="checkbox"/> Ambulance Services: <input type="checkbox"/> Ground Ambulance <input type="checkbox"/> Air Ambulance <input type="checkbox"/> Organized Sport – Submit Proof of Participation <input type="checkbox"/> Transportation or Lodging <input type="checkbox"/> Other: Explain _____		
DATE OF ACCIDENT: ____ / ____ / ____ TIME OF ACCIDENT: _____ <input type="checkbox"/> AM <input type="checkbox"/> PM Was Accident Work Related? <input type="checkbox"/> Yes <input type="checkbox"/> No Where did Accident Happen? _____ Was a Police Report filed? <input type="checkbox"/> Yes <input type="checkbox"/> No if yes, please attach a copy of the report. Tell us how your accident/injury happened: _____ _____		
PATIENT INFORMATION		
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."		
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

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: 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, Kansas, Nebraska, Oregon, and Vermont: 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.

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, Virginia 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.