Guardian Life Insurance Company
P.O. Box 14317
Lexington KY 40512
Phone: 1-800-541-7846
Fax: 920-749-6275

FAQ'S REGARDING WAIVER OF CANCER INSURANCE PREMIUM

What is Waiver of Premium?
Waiver of premium allows an employee's Cancer coverage to continue without premium being charged while they are on disability. This benefit may apply to employer and/or employee paid benefits.

What are the eligibility requirements for Waiver of Premium?
Please review your employee certificate booklet for your plan's specific requirements.

When should I submit my application for Waiver of Premium?
Even though the request will not be approved before the waiting period is met, the employee should submit the completed application as soon as possible.

When will my waiver of premium become effective?
If approved, the waiver of premium will be effective once the waiting period is met.

SUBMITTING AN APPLICATION FOR WAIVER OF CANCER INSURANCE PREMIUM

What to Expect:
1. The initial review of the claim will typically be completed within 15 calendar days. If additional information is required, you will be contacted once this initial review is completed.

2. Please note, due to the contractual differences between the Cancer Waiver of Premium benefits, Long Term Disability, and Social Security Disability, receipt of Long Term Disability or Social Security Disability benefits does not guarantee your entitlement to Cancer Waiver of Premium benefits.

Instructions for Employee:
1. Employee must complete and sign Sections 1 (Employee Information) and 2 (Disability Information) of this form.

2. Provide Attending Physician's State of disability (GG-117) completed by each attending physician who treated the patient during the period of disability. If you have recently submitted a disability claim to Guardian, we will utilize the medical information received with your disability claim. If additional information is needed, we will contact you.

Instructions for Employer:
1. Employer must complete and sign Section 3 (Employer Section) of this form.

2. Provide a copy of the employee's Enrollment Form(s) and any Beneficiary Designation/Change forms.

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Guardian

Application for Waiver of Cancer Insurance Premium

Send to: Cancer Claims, PO Box 14317 Lexington KY 40512 Customer Service: (800) 541-7846, Fax: (920) 749-6275
Documents can be returned electronically at www.guardianlife.com/forms. Select the "Benefits through work" option and click the "Secure Channel" link to send your private information.

Section 1: Employee Information

1. Employer Name:	2. Plan Number:	☐ Male ☐ Female
3. Employee's Name:	4. Date of Birth:	5. Social Security Number:
6. Employee's Address:	City	State Zip
7. Home telephone number:	8: Email Address	
9. Please indicate acceptable methods of contact: ☐ Home Phone	☐ Cell Phone ☐ Email	

Section 2: Disability Information

10. Date Last Worked	11. Cause of Your Disability	12. Date Present Disability Began

13. Name(s) of all Physicians/Providers who have treated you since the beginning of your disability:

Name	Address (City, State)	Phone Number	Date of Treatment

14. Have you performed any type of work (either for this employer, another employer, or through self employment) since your disability began?
☐ Yes ☐ No *If yes, provide the below information:*

Name of Employer and Contact Information	Type of Work	Hours Worked per Week	Date Employment Began

15. Describe any other income you are receiving or are eligible to receive as a result of your disability (e.g. Social Security, Worker's Compensation, State Disability, Pension, Disability/Retirement, Group Disability, No Fault)

Source	Plan No	Claim No	Amount/Frequency	Date Claim Filed	Date Income Began/Ends
					____/____/____ - ____/____/____
					____/____/____ - ____/____/
					____/____/____ - ____/____/

16. I authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manger, 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 know that I may request and receive a copy of this authorization. I have the right to cancel this authorization in writing at any time. 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 such violation."
"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 Date

Section 3: Employer Section

1. Employer Name: | 2. Plan Number:

3. Employer Address | City | State | Zip

4. If branch or affiliate, name & relationship to parent company: | 5. Claim Branch (if applicable)

6. Contact Person | 7. Telephone No | 8. Email Address

9. Employee Name: | 10. Social Security Number: | 11. Date of Birth

12. Date of Employment | 13. Date Insurance Effective Under This Plan | 14. Employee's Occupation/Job | 15. Insurance Class No

16. Hours Worked Per Week | 17. Normal Work Schedule
☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun

18. Actual Last Day Worked | 19. Date Employment Terminated (if applicable) | 20. Employee's Group Cancer Premiums Paid Through

21. If the employee was not actively at work immediately prior to his/her disability, please indicate the reason:
☐ Leave of Absence ☐ Resigned ☐ Layoff ☐ FMLA ☐ Retirement ☐ Other

22. Base Wage as of redetermination date of your plan
$_____ ☐ Hourly ☐ Weekly ☐ Monthly

23. Please check which of the below documents your office has on file **and provide a copy of each with this claim form.**
☐ Enrollment Form ☐ Beneficiary Form ☐ Evidence of Insurability

24. Remarks

25. **I certify that the above information is true and complete.**

Authorized Signature and Title | Date

Guardian®

Attending Physician Statement for Waiver of Premium

Send to: Group Cancer Claims, P.O. Box 14317, Lexington, KY 40512 Customer Service: (800) 541-7846, Fax: (920) 749-6275

Documents can be returned electronically at www.guardianlife.com/forms. Select the "Benefits through work" option and click the "Secure Channel" link to send your private information.

EMPLOYEE SECTION

1. Employee Name	2. DOB ____/____/____	3. Plan Number
4. Address City State Zip		5. Phone Number ( )
6. Employer Name/Occupation		7. Employee Social Security#

AUTHORIZATION

8. I authorize any physician, medical practitioner, hospital, clinic, other health facility, consumer reporting agency, the Social Security Administration, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me 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 the medical history, mental or physical condition, or treatment of me. 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 have the right to cancel this authorization in writing at any time. 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."

Signature _____ Date ____ / ____ / ____

PHYSICIAN SECTION

Your patient is responsible for the cost of completing this form

Objective findings which substantiate or contribute to the patient's disability. Please attach pertinent medical records including, but not limited to, office visit notes, diagnostic test results, discharge summaries, operative reports, consultation reports and mental status exam (if applicable). This will help to expedite the claim processing and reduce additional requests and follow up.

1. Primary diagnosis:	ICD-10 code:
2. Secondary diagnosis(es):	ICD-10 code(s):

3. Subjective Symptoms:

CONDITION HISTORY

4. Patient's symptoms are the result of (check all that apply):

☐ Employment ☐ Pregnancy ☐ Other Accident
☐ Illness ☐ Motor Vehicle Accident ☐ Other _____

5. Date symptoms first appeared or accident occurred: ____/____/____	6. Date you feel this patient was first unable to work: ____/____/____	7. Date of first visit for this condition: ____/____/____
8. Frequency of treatment: ☐ Weekly ☐ Monthly ☐ Other _____	9. Date of most recent visit/treatment for this condition: ____/____/____	10. Date of last comprehensive examination: ____/____/____

11. Has this patient ever had a similar or related condition? ☐ Yes ☐ No
If "Yes", when ____/____/____ Explain _____

12. Was this patient referred to you by another physician? ☐ Yes ☐ No If "Yes", please supply physician's complete name and address:

13. Did you refer this patient to another physician for treatment of this or a related condition? ☐ Yes ☐ No
If "Yes", please supply the physician's complete name and address:

14. Please supply complete names and addresses of any other treating physicians or hospitals:				Treatment:	
Name	City	State	ZIP	From	To
_____				____ /____ /____	____ /____ /____
_____				____ /____ /____	____ /____ /____
_____				____ /____ /____	____ /____ /____

GG-117-CAN

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 a false or fraudulent 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.