Guardian The Guardian Life Insurance Company of America

Group Critical Illness Claim Form

Send to Guardian Life Insurance, PO Box 14334, Lexington, KY 40512 Customer Service: 1-800-541-7846 Fax (610) 807-2999 Email: criticalillnessbenefits@glic.com 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.

If you would like to have your Supplemental Health (Accident, Cancer, Critical Illness and Hospital Indemnity) benefit payment directly deposited into your bank account, please complete the attached DIRECT PAY ENROLLMENT AND AUTHORIZATION form. If you have completed this form in the past under current banking information, and received payments electronically, no need to submit it again.

EMPLOYEE SECTION	**To avoid delays, please fill in the identifying claim information on each page.**		
1. Employee's Name:	2. Plan Number:	3. Date of Birth:	4. Member ID:
5. Gender: ☐Male ☐Female	6. Marital Status:	7. Mailing Address: Email address:	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: ☐Male ☐Female	13. Marital Status:

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?
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. Has the insured ever had the same or similar condition in the past? ☐ Yes ☐ No Dates of prior treatment:
If yes, please provide names, addresses, telephone, and fax numbers of physicians who previously treated the insured.

20. 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

PLEASE CHECK CONDITION FOR WHICH YOU ARE CLAIMING A BENEFIT.
IMPORTANT: PLEASE ATTACH PERTINENT MEDICAL RECORDS INCLUDING BUT NOT LIMITED TO PROGRESS NOTES, TEST RESULTS, ADMIT/DISCHARGE SUMMARIES, AND OPERATIVE REPORT.
Not all benefits are available under your plan. Please refer to your certificate of coverage for specific benefits available under your plan.

CONDITIONS

Cancer and Benign Tumors:
- ☐ Benign brain or spinal cord tumor
- ☐ Bone marrow failure (Including Stem Cells)
- ☐ BRCA1 or BRCA2 Mutation
- ☐ Carcinoma In Situ
- ☐ Invasive Cancer (including Leukemia Multiple Myeloma)
- ☐ Skin Cancer

Chronic Disorders:
- ☐ Crohn's disease
- ☐ Epilepsy
- ☐ Lupus
- ☐ Ulcerative Colitis

Heart Disorders:
- ☐ Coronary Artery Disease (Stents, Angioplasty, Thrombectomy)
- ☐ Coronary Artery Disease - requiring a bypass
- ☐ Heart Attack
- ☐ Heart Failure (including Valve Replacement)
- ☐ Implantable Cardioverter Defibrillator (ICD)
- ☐ Pacemaker
- ☐ Sudden Cardiac Arrest

Lung and Vascular Disorders:
- ☐ Acute Respiratory Distress Syndrome (ARDS)
- ☐ Aneurysm
- ☐ Pulmonary Embolism
- ☐ Stroke - moderate
- ☐ Stroke - severe
- ☐ Transient Ischemic Attack (TIA)

Mental Health Disorders:
- ☐ Major Depressive Disorder - mild or moderate
- ☐ Mental Health Disorder - severe
- ☐ Post-Traumatic Stress Disorder (PTSD)

Neurological Disorders:
- ☐ Alzheimer's Disease - early Stage
- ☐ Alzheimer's Disease - advanced Stage
- ☐ ALS (Lou Gehrig's)
- ☐ Dementia - other causes
- ☐ Huntington's Disease
- ☐ Multiple Sclerosis (MS) - early Stage
- ☐ Multiple Sclerosis (MS) - advanced Stage
- ☐ Myasthenia Gravis
- ☐ Parkinson's Disease - early Stage
- ☐ Parkinson's Disease - advanced Stage

Pregnancy and Childbirth Disorders:
- ☐ Complications of birth
- ☐ Complications of pregnancy or delivery
- ☐ Infertility - non-surgical treatment
- ☐ Infertility - surgical treatment

Additional Disorders:
- ☐ Addison's Disease
- ☐ Coma
- ☐ Infectious Contagious Disease
- ☐ Kidney Failure
- ☐ Loss of Hearing
- ☐ Loss of Sight
- ☐ Loss of Speech
- ☐ Major Organ Donation
- ☐ Major Organ Failure (Liver, Pancreas, Lungs)
- ☐ Permanent Paralysis
- ☐ Severe Burns

CHILDHOOD CONDITIONS

Childhood Illnesses and Disorders:
- ☐ Autism Spectrum Disorder
- ☐ Cerebral Palsy
- ☐ Cleft Lip or Cleft Palate
- ☐ Clubfoot
- ☐ Congenital Heart Defect
- ☐ Cystic Fibrosis
- ☐ Diabetes - Type 1
- ☐ Down Syndrome
- ☐ Hemophilia
- ☐ Multisystem Inflammatory Syndrome (MIS)
- ☐ Muscular Dystrophy
- ☐ Spina Bifida

Guardian

Direct Pay Enrollment and Authorization – Supplemental Health Claims

For **faster** service please contact Customer Service at 1-800-541-7846 or:

1. Complete this form on-line at GuardianLife.com
2. Print, sign and scan it
3. Save the completed form to your computer
4. Upload via our *Secure Channel* at GuardianLife.com

To mail this form:
Guardian Supplemental Health Claims
PO Box 14317, Lexington KY 40512
To fax this form:
(920)-749-6275
To Email this form:
SuppHealthEFT@glic.com

For direct deposit of your Supplemental Health benefit payments to your checking or savings account, please include all of the information requested. Please allow up to 10 business days for processing, upon receipt of completed documentation. If you have any questions about completing this form, please contact us at (800) 541-7846.

1. Member Information:

Member Name:_____Member ID:_____Group #: _____

Preferred Phone #: _____Email: _____

2. Bank Information:

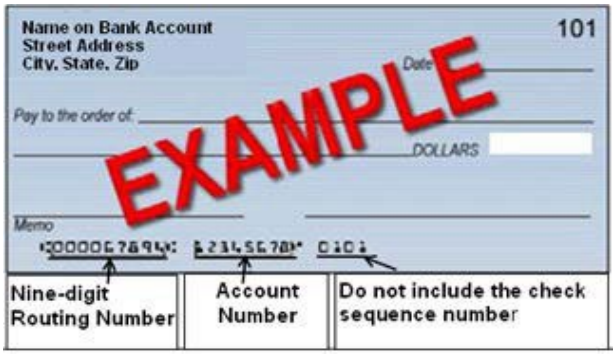
Account Type: (Choose One)

☐ Checking Account or ☐ Savings Account

Bank Name: _____

Bank Routing Number (ABA#): _____

Bank Account Number: _____



3. Sign and date this authorization:

I authorize Guardian Life Insurance Company of America ("Company") to deposit any benefits I am eligible to receive directly into the account and bank I have indicated above or to such other account as the bank or any successor bank designates as my account. I also authorize the Company to debit my account for any deposits made in error. I also understand that the direct deposit service will stay in effect until I notify the Company in writing of cancellation or until I am no longer eligible for or due payments, whichever comes first. I understand that I have the opportunity to view my EOBs and payment history via registration on GuardianLife.com

_____ _____

Member Signature Date

4. Joint Account Holder Agreement (Please check here if you are the sole account holder) ☐

I understand and agree that any funds deposited after the date of death of the Claimant that are not otherwise payable under the plan are to be immediately returned to Guardian Life Insurance Company of America.

_____ _____

Joint Account Holder Signature Date

Please register on GuardianLife.com to monitor your claim status and payment, as deposit may be made to your account prior to receiving your mailed explanation of benefits.

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.