Guardian

Hospital Indemnity Claim Form

Send to Guardian Life Insurance, PO Box 14752, Lexington, KY 40512 Customer Service: 1-800-541-7846 Fax (920) 749-6417 Email: HospitalindemnityBenefits@glic.com.Documents can be returned electronically at https://www.guardianlife.com/forms-and-claims. 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/MEMBER INFORMATION	**Do you have any of the following coverages with Guardian:** ☐ Accident ☐ Cancer ☐ Critical Illness		
1. Employee/Member Name:			2. Plan Number:
3. Date of Birth:	4. Member ID #:	5. Gender: ☐ Male ☐ Female	6. Marital Status:
7. Employee/Member Address:		8. Employee/Member email address:	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: ☐ Male ☐ Female	14. Relationship to the Employee/Member:	

CLAIM INFORMATION SECTION	☐ First Claim ☐ Continued Claim

REASON FOR TREATMENT / DIAGNOSIS
Provide details here:
Hospitalization (a Hospital Admission benefit is always included within your Hospital Indemnity coverage).
Were you admitted to the hospital 20 hours or more? ☐ Yes ☐ No
Admission date: _____ **Admission time:** _____ **Discharge date:** _____ **Discharge time:** _____
Was the admission to the Intensive Care Unit of the hospital? ☐ Yes ☐ No

(SEE SUBSEQUENT PAGES BEFORE SUBMITTING)

TREATMENT AND SERVICES

IMPORTANT: BEFORE SUBMITTING A CLAIM PLEASE READ BELOW:

All benefits listed may not be included under your plan. Please refer to your certificate of coverage for specific benefits available under your plan which can be found on "guardianlife.com".

Please check the treatment/service for which you are claiming a benefit. Submit copies of bills, itemized receipts of services or detailed medical carrier explanation of benefits in order to receive benefits.

Hospitalization

☐ Hospital Confinement

Was the confinement in the ICU of the hospital? ☐ Yes ☐ No

Dates in ICU: _____

☐ Hospital Short Stay

Admission Date: _____ Admission Time: _____

Discharge Date: _____ Discharge Time: _____

☐ Infertility Hospital Stay

Admission Date: _____ Admission Time: _____

Discharge Date: _____ Discharge Time: _____

☐ Newborn Nursery Care

Admission date: _____

Discharge date: _____

Emergency Care Benefits

☐ Emergency Room

☐ Urgent Care Facility

Mental Health and Substance Abuse

☐ Mental Health Assessment

☐ Mental Health Disorders - Inpatient

☐ Mental Health Disorders – Outpatient

☐ Substance Abuse Treatment - Inpatient

☐ Substance Abuse Treatment – Outpatient

Surgery

☐ Inpatient Surgery

☐ Outpatient Surgery

Office Visits, Testing, and Screenings

☐ Dental Screenings (you do not need to file a claim if you have Guardian Dental coverage, this benefit will be paid automatically and is for the member only)

Dental date of service: _____

☐ Diagnostic Tests

☐ Genetic Tests

☐ Office Visits

Prescription Drugs, Therapy, and Medical Equipment

☐ Durable Medical Equipment

☐ Outpatient Therapy (Therapies: Cardiac, Physical, Occupational, Respiratory, Speech, Chemo, and Radiation)

☐ Prescription Drugs

Rehabilitation, Home Care, and Hospice

☐ Home Health Care

☐ Hospice Care

☐ Rehabilitation Unit Confinement

Family Benefits

☐ Childcare

☐ Child Organized Sport

☐ Parental Care

☐ Pet Boarding

Transportation and Lodging

☐ Ambulance – Air

☐ Ambulance - Ground

☐ Lodging

☐ Transportation

Other Benefits

☐ Lifestyle and Fitness

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.

_____ Date_____

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)

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:

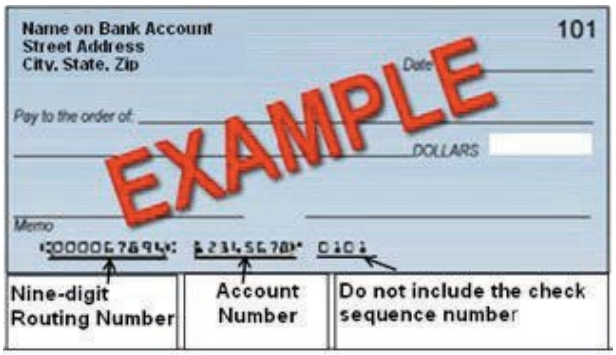
Account Type: (Choose One)

☐ 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 a 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.