Guardian

# INSTRUCTIONS FOR SUBMITTING A GROUP LIFE CLAIM

**Instructions for Employer/Plan Sponsor:**

*Please note, the terms member and employee can be used interchangeably on this form.*

1. Complete Sections 1-3 and sign and date the form in section 1.

2. If the employee had voluntary coverage for himself or his/her dependents, include the original enrollment form showing the initial election of the coverage.

3. Include the most recent beneficiary designation form.

**Instructions for Claimant**

1. Complete section 4 and sign and date the form. Submit the completed form along with a finalized death certificate.

2. If you are interested in the Guardian Asset Account payment option, prior to submitting your claim form, please contact us at 1-800-525-4542 to request the Guardian Asset Account election package, which includes disclosure information mandated by state law.

3. If the loss occurred outside of the United States or it's territories, we will require a Consular Report of Death of a U.S. Citizen Abroad. This report is issued by a U.S. embassy or consulate. Information on how to obtain this report can be found at http://travel.state.gov/content/passports/english/abroad/events-and-records/death/CRDA.html.

4. If you are claiming an Accidental Death benefit acceptable proof of loss is required and may include, but is not limited to, the following information:

a. Police or incident report;

b. Medical examiner's report with autopsy and toxicology; and

c. Any additional information deemed necessary during the course of our investigation.

5. If the designated beneficiary is a minor, trust, or estate, or the primary beneficiary is deceased, additional documentation is required. Please see below and contact our Group Life Claims department at 1-800-525-4542 with any questions.

**If the beneficiary is the estate of the insured:** Section 4 must be signed by an executor or administrator of the estate, provide the estate's tax ID number in question # 45. If a tax ID is not assigned to the estate, you can obtain one at https://sa.www4.irs.gov/modiein/individual/index.jsp. We also require the estate documentation showing the appointment of the executor/administrator.

**If the beneficiary is a minor:** Section 4 must be signed by the legal guardian of the minor. In most cases, documentation certifying guardianship of the minor's property and estate will be required.

**If the beneficiary is a trust:** Section 4 must be signed by the named trustee. A copy of the trust agreement pages including the name and effective date of the trust, named trustees/successors, and trustee's signature and date pages are also required. Please provide the trust's tax ID number in question #45. If a tax ID is not assigned to the trust you can obtain one at https://sa.www4.irs.gov/modiein/individual/index.jsp.

**If the primary beneficiary is deceased:** A copy of the primary beneficiary's death certificate is required. Section 4 should then be completed by the contingent beneficiary.

**If there is no named beneficiary or the named beneficiary is deceased and there is no contingent beneficiary:** Please call our Group Life Claims department for 800-525-4542 for instruction.

**What to Expect**

The initial review of a claim is typically completed within 15 calendar days of receipt. If additional information is required, we will contact you to provide the status of the claim.

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Guardian

# Group Life Claim Form

If the claimant (beneficiary) is unable to provide a handwritten signature due to technical limitations resulting from the COVID-19 pandemic, Guardian will accept their typewritten name in lieu of a signature on an interim basis. The claimant (beneficiary) must check the box below their signature line certifying that they understand that their typewritten name has the same force and effect as their signature.

For **faster** service please:
1. Complete this form on-line
2. The claimant can use the interim accommodation of typing their 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

**Section 1: Employer/Plan Sponsor Information (This section should be completed by the Employer/Plan Sponsor.)**

| 1. Planholder/Employer Name | 2. Plan Number | 3. Phone Number |
|---|---|---|
| 4. Planholder Address City State Zip | | 5. Claim Branch (if applicable) |
| 6. Contact Person | 7. Telephone Number | 8. Email Address |

9. Was the member's death the result of a workplace assault? ☐ Yes ☐ No
Did the death occur while the member was travelling on company business at the time of the incident? ☐ Yes ☐ No

10. I certify that the information provided on this page is true and complete.

_____ Authorized Signature
_____ Title
_____ Date

**Section 2: Employee/Member Information (This section should be completed by the Employer/Plan Sponsor for all Employee/Member/Dependent claims.)**

| 11. Name of Member | 12. Date of Birth | 13. Social Security Number |
|---|---|---|
| 14. Address City State Zip | | 15. Date of Death |

16. If the member does not work at the home office location, please choose the appropriate reason below:
☐ Affiliate Location (Please provide name and address)
_____
☐ Travels for Work ☐ Works From Home ☐ N/A (Association/Union Plan) ☐ Other _____

| 17. Job Title | 18. For Salary Based Benefits, Annual Salary as of your plan's last redetermination date **and** effective date of salary $_____ **effective**_____/_____/_____ |
|---|---|

19. Amount of Insurance Being Claimed
**Life:** Basic: _____ Voluntary: _____
**ADD (if applicable):** Basic: _____ Voluntary: _____

| 20. Insurance Class | 21. Date of Employment/Membership | 22. Effective Date of Insurance |
|---|---|---|
| 23. Actual Last Day Worked | 24. Hours Worked Per Week | 25. Normal Work Schedule ☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat ☐ Sun |
| 26. Date Employment/Membership Terminated: | | 27. Member's Group Life Premiums Paid Through: |

28. If the employee/member was not actively at work immediately prior to his/her death, please indicate the reason:
☐ Leave of Absence ☐ FMLA ☐ Terminated ☐ Resigned
☐ Disability ☐ Retired (not due to disability) ☐ Retired due to disability ☐ Layoff
☐ Other _____

29. Does your office have any record of a beneficiary designation form on file for this Employee/Member? **If yes, provide the most recent beneficiary designation form on file.** ☐ Yes ☐ No

**Section 3: Dependent Information (This section should be completed by the Employer/Plan Sponsor if the claim is for a dependent in addition to Section 2.)**

30. Was the Employee actively at work until the date of the dependent's death? ☐ Yes ☐ No
*If no, please provide an explanation:* _____

| 31. Name of Dependent | 32. Date of Birth | 33. Social Security Number |
|---|---|---|
| 34. Address City State Zip | | |
| 35. Relationship to Employee/Member | 36. Date of Death | 37. Effective Date of Insurance |

**Section 4: Decedent/Claimant Information** (This section should be completed by the claimant.)

If beneficiary is a minor, boxes 54-55 should be completed. The legal guardian's information should be entered in boxes 49-52.

| 38. Name of Deceased | 39. Plan Number | 40. Deceased's Social Security Number |
|---|---|---|
| | | |

| 41. Deceased's Date of Birth | 42. Date of Death | 43. Cause of Death |
|---|---|---|
| | | |

| 44. Name of Person Claiming Benefit | 45. Social Security Number | 46. Date of Birth |
|---|---|---|
| | | |

| 47. Relationship to Deceased | 48. If Deceased is your spouse, date of marriage _____/_____/_____ | 49. Telephone Number<br>Home: Cell: |
|---|---|---|
| | | |

50. Address City State Zip

| 51. Email Address | 52. Please Indicate Acceptable Methods of Contact<br>☐Cell ☐Home ☐Email |
|---|---|
| | |

53. Have you assigned any portion of this benefit to a funeral home, mortuary, crematorium, etc. to cover final expenses? **If so, please attach the notarized assignment(s) for final expenses.** ☐ Yes ☐ No

Numbers 54-55 only need to be completed if the beneficiary is a minor.

| 54. Name of Guardian of Minor Beneficiary | 55. Has guardianship of the minor's estate been established? **If yes, please attach court order.** ☐ Yes ☐ No |
|---|---|
| | |

Method of Payment

You may select from two options: 1) Lump sum payment via a single check or 2) Guardian Asset Account. Note: If you do not elect an option, the proceeds will be paid in a single lump sum. **If you prefer payment via a lump sum check, please check below:**

☐ Lump sum payment via a single check

2) Guardian Asset Account. This option is only available if the proceeds exceed $10,000.00. This is an interest-bearing draft account administered by the Bank of New York Mellon. Additional information is required in order to elect this option. If you are interested in the Guardian Asset Account payment option, prior to submitting your claim form, please contact us at 1-800-525-4542 to request the Guardian Asset Account election package, which includes disclosure information mandated by state law for your review prior to electing this payment option.

By signing below, I acknowledge:
1. All information I have given is true and complete to the best of my knowledge and belief.
2. I have read the applicable Fraud Warning(s) provided in this form.

Under penalty of perjury, I certify:
1. That the number shown on this form is my correct taxpayer identification number; and
2. That I am not subject to IRS required backup withholding as a result of failure to report all interest or dividend income; and
3. I am a U.S. citizen, or a U.S. resident for tax purposes.

*(Please note: You must cross out item 2 above if the IRS has notified you that you are currently subject to backup withholding because you failed to report all interest and dividend income on your tax return.)*

I make claim to The Guardian Life Insurance Company of America. I agree that the written statements and affidavits of all the physicians who attended or treated the deceased and all other papers called for by Guardian are part of this Group Life Claim Form I agree that furnishing this form or any supplement to Guardian is not an admission by it that there was any insurance in force on the life of the person in question nor a waiver of any of its rights or defenses. I waive all provisions of law expressly forbidding any consumer reporting agency, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information about the deceased 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, pharmacies or pharmacy benefit managers regarding the deceased's 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 have the right to cancel this authorization in writing at any time. 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 agree that a photocopy of the authorization shall be as valid as the original. I agree that this authorization is 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.**

The IRS does not require consent to any provision of this document other than the certification to avoid backup withholding. ."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: _____ 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.**

## 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.

# Guaranty Association Coverage Disclosure

**Alaska, California, Colorado, Connecticut, Illinois, Iowa, Maine, New Hampshire, New Jersey, Ohio, Virginia, West Virginia: These proceeds may be guaranteed by the State Guaranty Associations. State Guaranty Association coverage limits vary by state. Please contact the National Organization of Life and Healthy Guaranty Associations (www.nolhga.com); Telephone: (703)481-5206 for more information about the coverage or limitations of your account.**