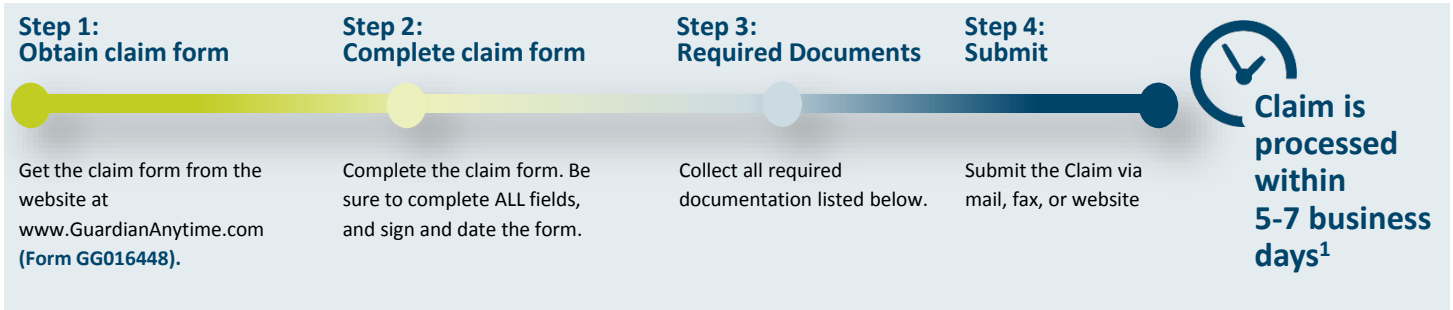


Submitting an Accident Claim

Guardian works smarter to keep claims submission easy for you – by offering a simple claims process, you can focus on your recovery. Simply fill out the form, collect your required documentation (listed below) and submit your claim by mail, fax or email. Your claim is processed within 5-7 business days.¹



<p>Accident Claim Submission</p>	<p>Mail: Guardian Life Insurance Accident Claims PO Box 14315 Lexington, KY 40512</p> <p>Fax: 920-749-6299</p> <p>Secure E-mail: www.GuardianAnytime.com click secure channel, select cru@glc.com</p>
<p>Required Documents</p>	<ul style="list-style-type: none"> • Completed Employee claim form • Employer and Attending Physician Sections (if applicable) • Documentation identifying services rendered with provider, patient’s name, and dates and types of services/treatment. This could include, but is not limited to, copies of the following: <ul style="list-style-type: none"> — Medical bills from the provider(s) — Medical records — Explanation of Benefits from Medical Carrier — ER Report — For the Child Organized Sports provision, proof of participation is required (e.g. a registration form).

Form GG016448

GUARDIAN The Guardian Life Insurance Company of America **Group Accident Claim Form**

Send to Guardian Life Insurance, Accident Claims, PO Box 14315, Lexington, KY 40512
Customer Service: 1-800-541-7848 Fax: (920) 749-6299
Secure E-mail: [www.GuardianAnytime.com](mailto:cru@glc.com), click secure channel, select cru@glc.com

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: ____ AM ____ 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 <i>If yes, please attach a copy of the report.</i>		
Tell us how your accident/injury happened: _____		

Questions about your claim?

Call 1-800-541-7846

1. Provided all required information is received. Guardian's Accident Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. This policy provides Accident insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. **IMPORTANT NOTICE—THIS POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS.** Policy Form #GP-1-AC-IC-12.

