Submitting a Critical Illness 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

Step 1: Obtain claim form Step 2: Complete claim form

Step 3: Required Documents Step 4: Submit

Claim is processed within 5-7 business days1

Get the claim form from the website at www.GuardianAnytime.com

(Form GG-016218).

Complete the claim form. Be sure to complete ALL fields, and sign and date the form.

Collect all required documentation listed below.

Submit the Claim via mail, fax, or website

Critical Illness Claim Submission

Mail:

Guardian Life Insurance Critical Illness Claims PO Box 14334 Lexington, KY 40512

Fax:

610-807-2999

Secure E-mail:

www.GuardianAnytime.com click secure channel, select **cru@glic.com**

Required Documents

- 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:
 - Medical bills from the provider(s)
 - Medical records
 - Explanation of Benefits from Medical Carrier
 - ER Report

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GUARDIAN* The Guardian Life Insurance Company of America				Group Critical Illness Claim Forn		
end to the Life Department Cli ocuments can be returned ele	im Office, Critical stronically at www	Illness Team, Box 14334, Le GuardianArytime.com. Click	xington, KY 40512 on "Secure Channel" on the Guardian	Customer Service: (8 Anytime home page.	00) 268-2525 Fax: (610) 807-2999	
EMPLOYEE SECTIO	N To avo	id delays, please fill in	the identifying claim informat	ion on each page.		
1. Employee's Name:			2. Plan Number:	3. Date of Birth:	Social Security #:	
Gender: 8. Marital 7. Mailing Address: Status: 7. Mailing Address:				8.Preferred Telephone Number		
DEPENDENT SECTION	Email addres		THE CLAIM IS FOR A DEPEND	ENT		
Dependent's Name:					10. Dependent's Preferred Telephone Number:	
11. Date of Birth:		12. Gender: 1 Male Female	13. Marital Status:	14. Social Secu	rity Number:	
CLAIM INFORMATIO	N SECTION			'		
15. Please list the condit	ion for which y	ou are claiming a benefit	t (see page 2). 16.	On what date did the	symptoms first appear?	
			a separate sheet of paper.		_	
17 Please indicate name of hospital & dates of hospitalization, if					 Insured's date of death, if applicable: 	
Name of hospital: 19. Name, complete add	ress, telephone		nitted:/ Dischar	ged://	-	
20. Names, complete ac	ldresses, telep	hone and fax numbers o	of physicians and hospitals that to	reated the insured for	this illness or injury:	

Questions about your claim?

Call 1-800-268-2525

1. Provided all required information is received. Guardian's Critical Illness 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 limited benefits health 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. Policy Form #GC-C1-11, et al.



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