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

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 your Human Resource department, or via the website at www.GuardianAnytime.com (Form GG016448). 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

Accident Claim Submission

Required

Documents

Mail:

Guardian Life Insurance Accident Claims PO Box 14315 Lexington, KY 40512

Fax:

920-749-6299

Secure E-mail:

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

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- Completed Employee claim form
 Employer and Attending Physician Sections
- (if applicable)Documentation identifying services rendered with provider, patient's name,
 - 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
 - For the Child Organized Sports provision, proof of participation is required (e.g.
 - a registration form).

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GUARDIAN* The Guardian Life Insurance Company of America Send to Guardian Life Insurance, Accident Claims, PO Box 1431				Group Accident Claim For			
Customer Service: 1-800-54	41-7846 Fa	x: (920) 749-6299					
Secure E-mail: www.Guard EMPLOYEE INFORMATION		com, click secure chans	nel, select (ru@glic.com			
1. Employee's Name:					2. Plan Number:		
3. Date of Birth;	4. 5	4. Social Security #:		5. Gender:		6. Marital Status:	
				Male F			
7. Employee's Address:			8.1	Employee email address (optional):		9. Preferred Telephone Num	
DEPENDENT INFORMA	ATION	Complete this section, if the	he claim is f	or a dependent. Other	orwise, proceed	to the daim information section	
10. Dependent's Name:			,	 Dependent's Prefe Number: 	12. Dependent's Date of E		
13. Gender: 14. Relationship to the ☐ Male ☐ Female			mplayee:	ployee: 15. Deper		dent's Social Security Number:	
FIRST CLAIM ACCIDENT HOSPITAL CONFINI		CONTINUED CLAIM KNESS) *Separate Rider	Required				
_ nour tire con in	Emeri (uic			ON SECTION			
						ttach any documentation you m fracture benefit, a copy of the	
Fracture (Bone)/Disk Hospital Admission/C Medical Expenses Ambulance Services: Organized Sport – Si	Ground Gr	ory (Accident) ad Ambulance Air Ar If Participation	mbulance				
Other: Explain	• •	THE OF LOOPER		П. П.			
	7 Yes	TIME OF ACCIDE	NT:	_ LIAM LIPM			

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.



File #2016-23236 Exp. 5/18