



Group Life Claims, P.O. Box 26035, Lehigh Valley, PA 18002-6035

Customer Service: (800) 525-4542, Fax: (610) 807-8266

Email address: Group_Life_Claims@GuardianLife.com

CLAIMANT SECTION		If the Life Insurance is payable to an estate, executor, administrator, minor, or trust, or if a primary beneficiary is deceased or the benefit is assigned, see the Group Administration Manual for information or contact Guardian at (800) 525-4542	
1. Planholder/Employer Name		2. Plan Number(s) G-	
3. Deceased's Name		4. If claim is for a dependent spouse, please enter date of marriage / /	
5. Date of Birth	6. Deceased's Place of Birth	7. Deceased's Soc. Sec. # - -	8. Cause of Death
9. Deceased's Address (street, city, state, zip)			
10. Your Relationship to Deceased		11. Do you claim this insurance as beneficiary? <input type="checkbox"/> Yes <input type="checkbox"/> No	12. If "no", in what capacity do you make this claim?
13. Claimant's Full Name (Please Print)			
14. Claimant's Soc. Sec. # or Tax ID - -		15. Claimant's DOB / /	16. Claimant's Telephone No. () -
17. Claimant's Address (street, city, state, zip)			

Under penalties of perjury, I certify that the number shown on this form is my correct Taxpayer Identification Number (or Social Security Number) (or that I am waiting for a number to be issued to me), and that I am not subject to backup withholding, either because I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or because the IRS has notified me that I am no longer subject to backup withholding. (If you do not give us your valid Social Security or Tax ID Number, the IRS may require us to withhold 31% of the interest payment made to you.)

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 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 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 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."

INDICATE DESIRED MODE OF PAYMENT

Unless the insured selected a payment option while the insured was living, you have the right to choose how payment of the death proceeds will be made to you. If the amount payable to you is more than \$10,000.00, our usual method of payment is to open an account in your name at State Street Bank giving you complete control and immediate access to all of your funds. If the amount of proceeds is lower than above, a single check will be payable to you. The other settlement options listed below remain available while the account is active and meet the requirements of the account (see page 2 for more information).

- Place proceeds into the Guardian Asset Account, GAA
- Installment payments
- Other manner of payment: _____

"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: _____

EMPLOYER SECTION		Please enclose employee's original Enrollment Form, approved application if applicable, any beneficiary changes, and Death Certificate.	
1. Planholder/Employer's Address		2. Telephone Number () -	
3. If branch or affiliate, name and relationship of parent company:			
4. Employee's Name			

EMPLOYER SECTION		CONTINUED			
5. Social Security #		6. Job title at last time worked		7. Certificate #	8. Insurance Class
9. Annual salary excluding bonus, overtime, and special compensation on the redetermination date of your plan \$					
10. Amount of Ins. \$		11. Date last worked full time / /		12. Schedule at last time worked _____ Hours per day _____ Days per week	
14. Date of Employment / /		15. Date Employee's Insurance Effective / /		16. Date Dependent's Insurance Effective / /	
17. Date Employment Terminated / /					
18. If employment ended before death, check the reason <input type="checkbox"/> Dismissed <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Disability <input type="checkbox"/> Resigned <input type="checkbox"/> Retired <input type="checkbox"/> Layoff <input type="checkbox"/> Other _____					
19. Do you recommend payment of claim? <input type="checkbox"/> Yes <input type="checkbox"/> No		20. Remarks			
21. I certify that the employee named above has been a full-time, active employee for whom premiums have been paid.					
Authorized Signature and Title _____				Date _____	
PHYSICIAN'S SECTION		Please attach certified copy of the Death Certificate. We reserve the right to require a Physician's Statement if it is necessary for a proper consideration of claim.			
1. Deceased's Name				2. Age	
3. Address (street, city, state, zip)					
4. How long have you known deceased?		5. Date of first attendance in last illness / /		6. Date of final attendance / /	
				7. Date of Death / /	
8. Place of Death					
9. Cause of death: Disease or condition directly leading to death (disease, injury or complication which caused death, not mode of dying such as heart attack, asthenia, etc.)					
10. Morbid conditions giving rise to the above cause of death:					
11. Other significant conditions contributing to but not causing death:					
12. If death was due to suicide, homicide, or accident, state which and describe briefly:					
13. Was there an inquest? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", please give results:					
14. Was there an autopsy? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", please give results:					
15. Did you previously treat or advise deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", please give:					
Condition		Dates		Duration	
				Results	
16. Did deceased receive treatment during the past three years from another physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes", please give:					
Name & Address of Physician		Conditions		Dates	
				Results	
17. Physician's Address			City	State	Zip
				18. Telephone Number () -	
19. Physician's Signature				Date	
<p>Guardian Asset Account</p> <p>Guardian will mail you an information kit explaining the account along with personalized checks and a supplemental contract. Once payment is made to you via the Guardian Asset Account, you will have immediate access to the entire amount plus any interest accumulated. You may withdraw funds at any time by writing a check for any amount above \$250 to the entire amount of proceeds. You have the ability to designate a beneficiary for the account where permitted by law. This account is not a bank checking account. The full amount of the proceeds and all interest earned are guaranteed by the full faith and credit of Guardian. Interest is compounded daily and credited monthly to your Account's balance.</p> <p>This account is an accommodation that Guardian offers to beneficiaries. Guardian will pay the fees associated with maintaining the account. You will not be charged for checks and there is no limit to the number of checks you write, however, you will not be able to add additional funds to this account.</p> <p>Unless the insured selected a payment option while the insured was living, you have the right to choose how payment of the death proceeds will be made to you. If the amount payable to you is more than \$10,000.00, our usual method of payment is to open an account in your name at State Street Bank giving you complete control and immediate access to all of your funds. If the amount of proceeds is lower than above, a single check will be payable to you.</p> <p>The Guardian Asset Account operates as a draft account administered by State Street Bank, Boston, Massachusetts. Under this payment method, Guardian will hold the proceeds within its General Account and pay you interest. For information on the current interest rate, please call 1-800-525-4542. You will receive monthly statements of your account indicating principal and accrued interest. Interest earned on your account may be taxable. It is recommended that you consult a tax adviser to determine your tax consequences.</p> <p>You may choose another payment option or override the Guardian Asset Account by completing the section entitled, "Other manner of payment" on the front of this form. For example, you may request that a percentage of the death proceeds be paid to the Guardian Asset Account and the remainder be paid in a lump sum check.</p> <p>For more information contact Guardian at 1-800-525-4542.</p>					