GUARDIAN® The Guardian Life Insurance Company of America

Group Cancer Claim Form

Send to Guardian Life Insurance, Cancer Claims, PO Box 14317, Lexington KY 40512
Customer Service: 1-800-541-7846 Fax: (920) 749-6275
Secure E-mail: www.GuardianAnytime.com, click secure channel, select cru@glic.com

EMPLOYEE SECTION	**To avoid delays, please fill in the identifying claim information on each page.**		
1. Employee's Name:	2. Plan Number:	3. Date of Birth:	4. Social Security #:

5. Gender: ☐ Male ☐ Female	6. Marital Status:	7. Mailing Address: Email address (optional):	8.Preferred Telephone Number:

DEPENDENT SECTION	**COMPLETE THIS SECTION IF THE CLAIM IS FOR A DEPENDENT.**	
9. Dependent's Name:	10. Dependent's Preferred Telephone number	11. Dependent's Date of Birth:

12. Gender: ☐ Male ☐ Female	13. Relationship to the employee:	14. Dependent's Social Security Number:

CLAIM INFORMATION SECTION

INSTRUCTIONS FOR FILING CANCER CLAIMS

Please answer the following questions:

Have you been diagnosed with Internal Cancer? ☐ Yes ☐ No

(Internal Cancer is defined as a Cancer contained within the body. Internal Cancers do not include Skin Cancer except for melanomas with specific classifications.)

Have you been diagnosed with Skin Cancer? ☐ Yes ☐ No

CANCER CLAIMS:

- ☐ A pathology report diagnosing cancer must accompany your first claim for that diagnosis of cancer. (The hospital or doctor will furnish this report to you at your request.) If the diagnosis of cancer was made by clinical information instead of pathological means, please submit the clinical evidence that established a positive diagnosis of cancer.
- ☐ Include a copy of your itemized hospital billing if you were hospitalized.
- ☐ Have the doctor complete the Physician's Statement and attach an itemized billing showing the diagnosis, services provided and the actual charges made to you.
- ☐ Any other bills pertaining to the claim, such as anesthesia, chemotherapy or radiation treatments, ambulance, lodging, or travel, may be included.
- ☐ *Transportation and Lodging* – Please review your policy to determine what expenses are covered. Send us a statement detailing your transportation and lodging expenses. This information should include mileage, where you traveled from and to, lodging receipts and medical verification of treatment for this time.

PATIENT INFORMATION

I authorize any physician, medical practitioner, hospital, clinic, other health facility, consumer reporting agencies, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information about me 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 my 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 this 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."

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.

"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 of employee or Power of Attorney (attach Power of Attorney papers if applicable) Date

_____ _____
If a dependent claim, signature of adult dependent or Power of Attorney (attach Power of Attorney papers if applicable) Date

CANCER CLAIM FORM – Physician's Statement

IMPORTANT INSTRUCTIONS: Your patient is filing a claim for the Cancer benefit indicated on page 1 of this form. Please answer questions 1-8 below and then complete sections 2-5.

SECTION 1 – PHYSICIAN STATEMENT- to be completed by the treating physician for the claimed critical illness.

Policy Number	
Patient's name:	Patient's date of birth:

1. For what condition(s) are you treating this patient? _____
2. When did symptoms first appear? _____
3. On what date were you first consulted for the above condition(s)? _____/_____/_____
4. Has the patient ever been treated for the same or similar condition in the past? ☐ Yes ☐ No
   If yes, please provide the diagnosis and date._____
5. Has a biopsy been performed? ☐ Yes ☐ No If yes, please provide a copy of the pathology/cytology report.
6. Is this a malignant tumor that: a) has uncontrolled growth of malignant cells? ☐ Yes ☐ No b) Invaded normal tissue? ☐ Yes ☐ No c) is a carcinoma in-situ? ☐ Yes ☐ No
7. What is the TNM classification? _____
8. Does the patient have a history of any risk factors such as pre-malignant conditions or conditions with malignant potential, such as myelodyplastic and myeloproliferative disorders, carcinoid, leukoplakia, actinic keratosis, polycythemia, and nonmalignant melanoma, moles or similar diseases or lesions? ☐ Yes ☐ No If yes, please give dates of consultation(s) and diagnosis (es):

   _____

   _____

SECTION 2 – PHYSICIAN INFORMATION

1. Was this patient referred to you by another physician? ☐ Yes ☐ No If "Yes", please provide contact information below.

Referring Physician's Name:			Specialty	
Address	City	State	Zip	Phone ( )

2. Has this patient been hospitalized for this condition? ☐ Yes ☐ No If "Yes", please provide contact information:

Hospital Name				
Address	City	State	Zip	Phone ( )

SECTION 3 – ATTACH SUPPORTING DOCUMENTATION

PLEASE ATTACH PERTINENT MEDICAL RECORDS INCLUDING BUT NOT LIMITED TO PROGRESS NOTES, DIAGNOSTIC TEST RESULTS, DISCHARGE SUMMARIES, OPERATIVE REPORTS, CONSULTATION REPORTS AND MENTAL STATUS EXAM (IF APPLICABLE). THIS WILL HELP TO EXPEDITE PROCESSING OF THE CLAIM AND REDUCE ADDITIONAL REQUESTS AND FOLLOW UP. YOUR PATIENT IS RESPONSIBLE FOR THE COST OF THE MEDICAL RECORDS.

(PHYSICIAN'S STATEMENT CONTINUED ON PAGE 3)

SECTION 4 – HOSPITALIZATION AND SERVICE(S) INFORMATION

Policy Number

Patient's name:	Patient's date of birth:

Hospitalization Information

Was patient hospitalized as a result of this diagnosis? ☐ Yes ☐ No If additional dates exist, please attach a copy of itemized billing.

Admission Date	Discharge Date	Admitting Diagnosis/ICD Code	Hospital Name (please include city and state.)

Surgery Information: Where was the surgery performed? ☐ Office ☐ Surgical Center ☐ Outpatient Hospital ☐ Inpatient Hospital

Name of facility: _____

Did the patient undergo surgery for this condition? ☐ Yes ☐ No If additional dates exist, please attach a copy of itemized billing.

Date of Service	Diagnosis/ICD Code	Surgery/CPT Code	Description of Surgery	Facility Name	Charges

Chemotherapy Information

Has patient received chemotherapy? ☐ Yes ☐ No If additional dates exist, please attach a copy of itemized billing.

Date	HCPCS/CPT Code	Drug Name and Method of Administration	Drug Charge

Radiation Therapy Information

Has patient received radiation therapy? ☐ Yes ☐ No If additional dates exist, please attach a copy of itemized billing.

Date	CPT Code	Description	Charge

SECTION 5 – PHYSICIAN SIGNATURE AND CONTACT INFORMATION

I attest to the fact that the information I have provided is, to the best of my knowledge, complete and accurate. "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.

X			Specialty	Date
	Physicians Signature	Physicians Name (PRINT)		

Phone #	Fax#	Address:

Fraud Warning Statements

The laws of several states require the following statements to appear on forms, as a substitute for fraud warnings that appear in other areas of the claim form:

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 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, Kansas, Nebraska, Oregon, and Vermont: 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.

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.

Maine, Tennessee, Virginia 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 and 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.

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 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.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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