GUARDIAN[SM] The Guardian Life Insurance Company of America

# STUDENT BLANKET INSURANCE POLICY
# DISABILITY CLAIM FORM

Send to: Group Long Term Disability Claims, P.O. Box 14333, Lexington, KY 40512 Customer Service: 1-800-538-4583 Fax: (610) 807-8221

## STUDENT SECTION

Blanket Insurance Policy #

1. Name:

2. Social Security Number:

☐ Male
☐ Female

4. Date of Birth:

5. Address (Street, City, State, Zip):

6. Home Telephone Number:

7. Full Name of College/University:

8. Last day attended classes on full-time basis:

9. Credit hours maintained just prior to date illness or injury occurred:

10. Year of school in when illness or injury occurred:

11. Are you currently a member or eligible for membership in the AMA?
☐ Yes ☐ No

12. Reason(s) for not attending classes beyond date listed under #8:

13. If illness/injury occurred during semester break, were you registered as a full-time student for the following semester?
☐ Yes _______________ # of hours ☐ No

14. Have you taken a leave of absence for any period of time? ☐ Yes ☐ No If yes, please indicate date started and date ended:

15. Have you continued to take classes part-time or full-time after date specified under #8 above? ☐ Yes ☐ No If yes, please indicate number of:
Part-time Credit hours____________ Date Started____________ Date Ended (if applicable)____________
Full-time Credit hours____________ Date Started____________ Date Ended (if applicable)____________

16. Nature of illness or injury:

17. Date first treated for illness or injury:

18. Date you expect to return to classes:
F/T____________P/T____________

19. Name and complete address of primary care physician:

20. Name and complete address of all physicians and hospitals that have treated you for this illness or injury:

21. Have you ever had the same or similar condition in the past? ☐ Yes ☐ No If yes, please give the date of first treatment and provide name and address of all past physicians who treated you:

22. Describe any income you are receiving or are eligible to receive as a result of your disability or from *employment*. Indicate source, date commenced and amount:

Are you currently working? ☐ Yes ☐ No

23. I authorize any physician, medical practitioner, hospital, clinic, other health facility, consumer reporting agency, the Medical Information Bureau, insurance or reinsurance company, employer, college, university or other educational institution 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 he 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 a statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, may be committing a criminal act.

_______________________________________ Signature of Student

_______________________ Date

## POLICYHOLDER SECTION

1. Policyholder/University Name:

2. Policy Number:

3. Policyholder/University Address (Street, City, State, Zip):

4. Telephone number:

5. Affiliated Teaching Institution (if different than above):

6. Student's Name:

7. Student's Date of Birth:

8. Student's Social Security Number:

9. Insurance Policy Effective Date:

10. Student's Effective Date:

11. Was student attending classes full-time on his/her effective date of insurance: ☐ Yes ☐ No

12. Was student insured under another group disability plan prior to his/her effective date under this plan? ☐ Yes ☐ No
If yes, please provide name of carrier and student's effective date of insurance under that plan:

Name ______________________ Effective Date ______________

13. Was student on an approved leave of absence for any period? ☐ Yes ☐ No If yes, please indicate dates of approved leave:

14. Last day student attended classes prior to disability:

15. Year of school student was in when disability commenced:

16. Full-time credit hour requirement of school:

17. Reason student no longer attending classes after date indicated under #14 above:

18. Number of credit hours student was enrolled for on or before disability commenced:

19. Did disability commence during a semester break? ☐ Yes ☐ No If yes, was student registered as a full-time student for the next semester? ☐ Yes ☐ No

20. Has student returned to school for any period since the date indicated under #14 above? ☐ Yes ☐ No If yes, please indicate:
☐ Part-time Number of credit hours_______________ ☐ Full-time Number of credit hours_______________

21. Is student receiving or eligible to receive benefits from any other source as a result of his/her disability and/or relation to the college or university? ☐ Yes ☐ No If yes, please indicate dates eligible and benefit amounts________________________________

By January 31 of the year succeeding that in which disability payments were made, Guardian will provide a W-2 statement to each insured who has received disability payments. The W-2 will show all payments made in the calendar year.

Guardian will also provide a written report to you by January 15 of the year succeeding that in which disability payments were made. Our report will give the name of each insured who received disability payments, the total amount of benefits paid, and the total amount of income tax withheld from each insured's payments. If taxes were withheld from an insured's disability payments, we must also give you the insured's social security number.

Contact your tax consultant if you have any questions about sick pay withholding.

22. Remarks:

23. I certify that I have reviewed the student section and that the student named above has been a full-time registered student for whom premiums have been paid.

**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 may also be subject to civil penalties, or denial of insurance benefits."**

**The laws of New York require the following statement appear:** 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 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.

______________________________________ ______________
Signature and Title Date

# Fraud Warning Statements

**The laws of several states require the following statements to appear on the claim form:**

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**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 a 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.

**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.

**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:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or 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 Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Ohio:** Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**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.

**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.