Employer's Statement for Group Critical Illness/ Hospital Admission/Wellness Claims

Send to the Life Department Claim Office, Critical Illness Team, PO Box 14334 Lexington KY 40512 Customer Service: (800) 268-2525 Fax: (610) 807-2999
Documents can be returned electronically at www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.

EMPLOYER SECTION:

1. Planholder/Employer Name:			2. Plan Number:
3. Planholder/Employer Address:	City	State	Zip
4. Telephone Number: Fax Number:	5. If branch or affiliate, name and relationship to parent company:		
6. Name & address of branch where employee works:		7. Employee's Name:	

Employee Information

8. Social Security #:	9. Date of Birth:	10. Date of full time employment:	11. Insurance Class:
12. Schedule at time last worked: _____ hours per day _____ days per week	13. Date Last Worked:	14. Date employment terminated:	15. Premiums Paid Through Date:

16. If insured with Guardian less than 24 months please provide:
Prior Carrier Name: ____
Employee Effective Date _________________
Spouse Effective Date _________________
Child Effective Date _________________

17. Date insurance effective under this plan:
Employee _________________
Spouse _________________
Child _________________

18. Please provide applicable benefit amount:
Critical Illness: _________________
Hospital Admission: _________________
Wellness: _________________

19. Remarks:

20. Does the employee contribute to the cost of their basic/core Critical Illness Benefit premium? ☐ Yes ☐ No
If "Yes", please provide the following information:
_____% paid by employer
_____% paid by employee ☐ Pre-Tax ☐ Post-Tax

21. Does the employee contribute to the cost of their voluntary/buy up Critical Illness Benefit premium? ☐ Yes ☐ No
If "Yes", please provide the following information:
_____% paid by employer
_____% paid by employee ☐ Pre-Tax ☐ Post-Tax

22. I certify that the employee named above has been a full-time, active employee for whom premiums have been paid.

Please Print Name: ____ Email Address: ____

Signature and Title: ____ Date: ____________________