GUARDIAN℠ The Guardian Life Insurance Company of America

STUDENT BLANKET INSURANCE POLICY
DISABILITY CLAIM FORM

Send to: Group Long Term Disability Claims, P.O. Box 26025, Lehigh Valley, PA 18002-6025 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.

_____ _____
Signature and Title Date