



Guardian Life Insurance Company
PO Box 14334
Lexington KY 40512
Phone: 1-800-525-4542
Fax: 610-807-8266

FAQ'S REGARDING WAIVER OF GROUP LIFE INSURANCE PREMIUM

What is Waiver of Premium?

Waiver of premium allows an employee's Life coverage to continue without premium being charged while they are on disability. This benefit may apply to employer and/or employee paid benefits.

What are the eligibility requirements for Waiver of Premium?

Please review your employee certificate booklet for your plan's specific requirements.

When should I submit my application for Waiver of Premium?

Even though the request will not be approved before the waiting period is met, the employee should submit the completed application as soon as possible.

When will my waiver of premium become effective?

If approved, the waiver of premium will be effective once the waiting period is met.

SUBMITTING AN APPLICATION FOR WAIVER OF GROUP LIFE INSURANCE PREMIUM

What to Expect:

1. The initial review of the claim will typically be completed within 15 calendar days. If additional information is required, you will be contacted once this initial review is completed.
2. Please note, due to the contractual differences between the Life Waiver of Premium benefits, Long Term Disability, and Social Security Disability, receipt of Long Term Disability or Social Security Disability benefits does not guarantee your entitlement to Life Waiver of Premium benefits.

Instructions for Employee:

1. Employee must complete and sign Sections 1 (Employee Information) and 2 (Disability Information) of this form.
2. Provide Attending Physician's State of disability (GG-117) completed by each attending physician who treated the patient during the period of disability. If you have recently submitted a disability claim to Guardian, we will utilize the medical information received with your disability claim. If additional information is needed, we will contact you.

Instructions for Employer:

1. Employer must complete and sign Section 3 (Employer Section) of this form.
2. Provide a copy of the employee's Enrollment Form(s) and any Beneficiary Designation/Change forms.

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Application for Waiver of Group Life Insurance Premium

If you are unable to provide a handwritten signature due to technical limitations resulting from the COVID-19 pandemic, Guardian will accept a type typewritten name in lieu of your signature on an interim basis. You must check the box below each signature line certifying that you understand that our typewritten name has the same force and effect as your signature.

For **faster** service please:

1. Complete this form on-line
2. Print and physically sign it or use interim accommodation of typing your name in the signature line
3. Save the completed form to your computer
4. Upload via our [Secure Channel](#)

To mail this form:
 Guardian Group Life Claims
 PO Box 14334, Lexington KY 40512

To fax the form:
 (610)-807-8266

Customer Service:
 1-800-525-4542

Section 1: Employee Information					
1. Employer Name:		2. Plan Number:		<input type="checkbox"/> Male	
				<input type="checkbox"/> Female	
3. Employee's Name:		4. Date of Birth:		5. Social Security Number:	
6. Employee's Address:		City		State Zip	
7. Home telephone number:			8. Email Address		
9. Please indicate acceptable methods of contact: <input type="checkbox"/> Home Phone <input type="checkbox"/> Cell Phone <input type="checkbox"/> Email					
Section 2: Disability Information					
10. Date Last Worked		11. Cause of Your Disability		12. Date Present Disability Began	
13. Name(s) of all Physicians/Providers who have treated you since the beginning of your disability:					
Name		Address (City, State)		Date of Treatment	
14. Have you performed any type of work (either for this employer, another employer, or through self employment) since your disability began? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, provide the below information:</i>					
Name of Employer and Contact Information		Type of Work		Hours Worked per Week	
				Date Employment Began	
15. Describe any other income you are receiving or are eligible to receive as a result of your disability (e.g. Social Security, Worker's Compensation, State Disability, Pension, Disability/Retirement, Group Disability, No Fault)					
Source		Plan No		Claim No	
				Amount/Frequency	
				Date Claim Filed	
				Date Income Began/Ends	
				___/___/___ - ___/___/___	
				___/___/___ - ___/___/___	
				___/___/___ - ___/___/___	



16. I authorize any physician, medical practitioner, hospital, clinic, pharmacy, pharmacy benefit manager, other health facility, consumer reporting agency, 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 or claim, or as may be lawfully required or permitted, or as I may further authorize. I understand that any information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal regulation governing privacy. I know that I may request and receive a copy of this authorization. I have the right to cancel this authorization in writing at any time. I agree that a photocopy of this authorization shall be as valid as the original. I agree that this authorization shall be valid up to 24 months (12 months in Kansas).

“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 such violation.”

"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

Date

I am unable to provide a signature due to the COVID-19 pandemic. I understand that my typewritten name has the same force and effect as my signature.



Section 3: Employer Section

1. Employer Name:		2. Plan Number:	
3. Employer Address		City	State Zip
4. If branch or affiliate, name & relationship to parent company:		5. Claim Branch (if applicable)	
6. Contact Person	7. Telephone No	8. Email Address	
9. Employee Name:		10. Social Security Number:	11. Date of Birth
12. Date of Employment	13. Date Insurance Effective Under This Plan	14. Employee's Occupation/Job	15. Insurance Class No
16. Hours Worked Per Week	17. Normal Work Schedule <input type="checkbox"/> Mon <input type="checkbox"/> Tues <input type="checkbox"/> Wed <input type="checkbox"/> Thurs <input type="checkbox"/> Fri <input type="checkbox"/> Sat <input type="checkbox"/> Sun		
18. Actual Last Day Worked	19. Date Employment Terminated (if applicable)	20. Employee's Group Life Premiums Paid Through	
21. If the employee was not actively at work immediately prior to his/her disability, please indicate the reason: <input type="checkbox"/> Leave of Absence <input type="checkbox"/> Resigned <input type="checkbox"/> Layoff <input type="checkbox"/> FMLA <input type="checkbox"/> Retirement <input type="checkbox"/> Other _____			
22. Base Wage as of redetermination date of your plan \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly		23. Amount of Life Insurance Basic: \$ _____ Voluntary: \$ _____	
24. Please check which of the below documents your office has on file and provide a copy of each with this claim form. <input type="checkbox"/> Enrollment Form <input type="checkbox"/> Beneficiary Form <input type="checkbox"/> Evidence of Insurability			
25. Remarks			
26. I certify that the above information is true and complete.			
_____ Authorized 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.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arkansas, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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, Nebraska and Oregon: 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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Kansas: 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 insurance fraud as determined by a court of law.

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 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.

New York: 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.

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.

Vermont: It is a crime for any person knowingly to provide material false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company, for any person knowingly to provide material false, incomplete, or misleading information concerning the sale of insurance or the status of an insurer, or for any person to misappropriate the funds of an insured or an applicant for insurance. Penalties include imprisonment, fines, and denial of insurance benefits.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.