Guardian Group
Guardian Life of The Caribbean Limited

CLAIM SUBMISSION FORM

DATE:_____

NAME OF POLICY OWNER:				
NAME OF INSURED : *(If different to the owner)*				
NAME OF CLAIMANT:				
CONTACT INFORMATION:	**HOME PHONE**	**WORK PHONE (INCL EXT)**	**CELL PHONE**	**EMAIL ADDRESS**
ADDRESS OF CLAIMANT:				
Relationship of Claimant to Policy Owner:				
Claim Type:	Named Beneficiary ☐	Probated Will ☐	Letters of Administration ☐	
Is the Claimaint/Beneficiary a Politically Exposed Person (PEP) Yes ☐ No ☐ If yes, please state the reason for PEP status:				
Identification (Attach Copy) (Valid form of photo ID required. 2 forms of ID required where the Claimant/Beneficiary is a PEP) ID#/PP#/DP# (Circle as appropriate & insert number)		Country of Issue	Expiration Date (Day/Month/Year)	
Policy Number/s:				

PART ONE (1) TYPE OF CLAIM SUBMITTED (Documents Required)

1. DEATH BENEFIT CLAIM ☐

- ☐ Certified copy of Death Certificate
- ☐ Certificate of Death (Internal Form)
- ☐ Certificate of Identity (Internal Form)
- ☐ Original Policy Contract or Discharge Form C
- ☐ Letters of Administration or Probate of Will
- ☐ ID of Beneficiary, Executor/ Administrator
- ☐ ID of Deceased
- ☐ Assignment Form/ Release of Assignment Form (Where applicable)

2. (A) CRITICAL ILLNESS BENEFIT CLAIM ☐ ..... Specify Critical Illness

(B) PERMANENT DISABLEMENT BENEFIT CLAIM ☐

- ☐ Claim for Living Benefit Form 1 – (Internal Form)
- ☐ Confidential Medical Report for Specific Illness Covered – (Interal Form)
- ☐ Medical Reports
- ☐ Original Policy Contract or Discharge Form C
- ☐ Letter from Assignee/Assignment Form/Release of Assignment Form (Where applicable)

3. ACCIDENTAL DEATH/ DISMEMBERMENT/ PERMANENT & PARTIAL DIABLEMENT BENEFIT CLAIM ☐

- ☐ Letter fom the Insured giving details of the Accident
- ☐ Medical Reports
- ☐ Police Reports (For Accidents Only) – (Requested by the Company)
- ☐ Medical Report from Doctor in attendance outlining condition, treatment duration and percentage of disability expected
- ☐ Post Mortem – (Requested by the Company)
- ☐ Toxicology – (Requested by the Company or Family)
- ☐ Coroner's Report – (Requested by Family)

4. (A) DISABILITY INCOME BENEFIT CLAIM ☐

(B) WAIVER OF PREMIUM BENEFIT CLAIM ☐

- ☐ Letter from Insured requesting waiver of payment and giving details of illness/ accident
- ☐ Letter from employer giving details of accident, illness, stating loss of income due to disability, sick leave, whether medically boarded etc.
- ☐ Medical Report from Doctor in attendance outlining condition, treatment duration and percentage of disability expected

5. HOSPITAL CASH CLAIM ☐

- ☐ Health Insurance Claim Form
- ☐ Receipt
- ☐ Letter from Hospital (must include length of period of stay)

6. HOSPITAL SURGICAL EXPENSE BENEFIT CLAIM ☐

- ☐ Health Insurance Claim Form
- ☐ Receipt / Proop of Payment & Detailed Invoice
- ☐ Incident Report/Accident Report detailing accident form
- ☐ Medical Report from Doctor in attendance outlining condition and treatment duration

7. ACCIDENTAL EMERGENCY PAYBACK CLAIM ☐

- ☐ Health Insurance Claim Form
- ☐ Receipts /Proof of Payment & Detailed Invoice
- ☐ Incident Report/Accident Report detailing accident form
- ☐ Medical Report from Doctor in attendance outlining condition and treatment duration

PART TWO (2) (FOR DEATH CLAIMS ON LIFE POLICIES ONLY)

FUNERAL GRANT – Under Section 140 of the Insurance Act, this can be applied for, up to a limit of $15,000.00 and will be paid directly to the Funeral Home.

Documents Required:

☐ Letter from Claimant requesting Grant

☐ Invoice from Funeral Home

☐ Death Certificate

PART THREE (3) PARTICULARS OF OTHER LIFE INSURANCE HELD BY THE LIFE ASSURED

NAME OF COMPANY	POLICY NUMBER	SUM ASSURED

PART FOUR (4)

To be completed ONLY if claim is made within Three (3) Years of Issue Date, Increase, Alteration or Reinstatement of Policy
Names and addresses of ALL Physicians (include personal physician) who attended to the deceased and Hospitals where treated within the past Five (5) years

DOCTOR'S NAME	ADDRESS	CONTACT NO.

PART FIVE (5) PAYMENT OPTIONS

This section is to be completed to advise how the Claimant would like the proceeds to be paid.

☐ **Payment by Cheque**

- Copy of ID of Claimant/Beneficiary

☐ **Payment to Transfer proceeds**

- Letter outlining Policy to transfer proceeds signed by Claimant/Beneficiary
- Copy ID of Claimant/Beneficiary

☐ Payment to Claimant/Beneficiary Account

- Signed Claim Discharge
- Copy of Bank Statement showing account to be credited
- Copy of ID of Claimant/beneficiary

GUARDIAN LIFE OF THE CARIBBEAN LIMITED
CLIENT FINANCIAL INSTITUTION'S DATA FORM

/Financial Institution's Name	Account Number	Account Type	Branch

Dated this …… day of …… 20

Signed by the accountholder(s) with authority to operate the relevant account(s)

…… Name of Account holder

…… Signature of Accountholder

BENEFICIARY/CLAIMANT NAME IN PRINT

BENEFICIARY/CLAIMANT SIGNATURE

_____ _____

DATE (DD/MM/YYYY)

_____

FOR INTERNAL USE ONLY

_____ _____ _____

NAME OF EMPLOYEE PROCESSING CLAIM (Please Print) SIGNATURE OF EMPLOYEE Date Claim Received by Head Office