National Guardian Life Insurance Company

Home Office: P.O. BOX 1191 Madison, WI 53701-1191
Administrative Office: Bay Bridge Administrators, P.O. Box 161690, Austin, Texas 78716
Telephone: 800-845-7519
Fax: 512-329-5463

STATEMENT OF CLAIMAINT
FOR PHYSICIAN EXPENSE FOR INJURY OR SICKNESS ONLY
(Do NOT use this form when filing for Disability)

Name of Employee_____ Social Security Number _____-_____-_____
Last Name First Name Middle Initial

Policy Number_____ Date of Birth _____
Month Day Year

Employee's Residence Address

_____
Street City State Zip Code

Telephone Number(s): (Day) _____ (Evening) _____

I am employed at _____ Occupation _____

_____
Street City State Zip Code

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1. Date of accident or illness began? _____
2. Nature of illness or accident? _____
3. Was the accident or illness work related? Yes or No
4. If accident, where and how did it happen? Explain fully _____
5. Dates of all Treatment Office _____

   What date(s) were you unable to work a full day? _____
   Hospital _____
   Admit. Date_____
   Discharge Date_____
6. Were you scheduled to work on the day of medical treatment? Yes or No
   If no, explain (Semester break, holiday, week-end, etc.)
   _____

   If yes, were you totally disabled and unable to work one full day on the date of medical treatment? Yes or No
   Date unable to work _____

CLAIM FRAUD WARNING STATEMENTS

For your protection, the laws of several jurisdictions, including California, Connecticut, District of Columbia, Florida, Maryland, New Hampshire, New Jersey, New York, Pennsylvania, Puerto Rico and others, require the following statements:

For residents in all jurisdictions except California, Connecticut, District of Columbia, Florida, Maryland, New Hampshire, New Jersey, New York, Pennsylvania, and Puerto Rico - *Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.*

For California residents - *Any person who knowingly presents a false or fraudulent claim for the payment of a loss 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.*

For Connecticut residents - *Any person who knowingly presents false or fraudulent claim, as determined by a court of competent jurisdiction, 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.*

For District of Columbia residents - *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.*

For Florida residents - 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.

For Maryland residents - 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.

For New Hampshire residents - Any person who, with a purpose to injure, defraud, or deceive an 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 under New Hampshire Insurance Statute RSA 638:20.

For New Jersey residents - *Any person who includes any false or misleading information in an application for an insurance policy is subject to criminal and civil penalties.*

For New York residents - 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.

For Pennsylvania residents - 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 and subjects such person to criminal and civil penalties.

For Puerto Rico residents - Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, and if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Employee's Signature _____ Date Signed_____

To be completed by Employer (Please Print)

Name of Employee_____
Last Name First Name Middle Initial

Social Security Number _____-_____-_____

Occupation_____

Date of Hire_____
Month Day Year

Did employee miss a day of work? Yes or No

If yes,

a. Date employee was actually last at work? _____

b. Has employee returned to work? If yes, please indicate date _____

Amount of Salary Monthly or Annually_____

Name of Employer_____

Address_____

Signature of Employee Representative_____Date_____

Printed Name & Title or Position_____

Employer's Telephone Number_____Fax Number_____

Email Address_____

Fax or mail the claim to the following address with a bill or medical documentation which list the date of service and the medical reason for your visit:

Bay Bridge Administrators, LLC
PO Box 161690
Austin TX 78716
Fax (512) 275-9350