GUARDIAN LIFE
OF THE CARIBBEAN LIMITED

Looking After Life since 1847
A Member of the Guardian Holdings Group

GUARDIAN LIFE OF THE CARIBBEAN LIMITED
GROUP HEALTH PLAN
DECLARATION OF INSURABILITY

PART A - GENERAL INFORMATION

POLICY HOLDER	
Address	Business Telephone No.
INSURED:	DATE EMPLOYED:
MARITAL STATUS ☐ Single ☐ Married	Home Telephone No.

PART B - PERSONS TO BE COVERED

Provide first name of insured and all family members to be covered plus last name of any member if different from the insured's

LAST NAME FIRST NAME	SEX	BIRTH DATE	AGE	HEIGHT	WEIGHT
Insured					
Spouse					
Dependant					
Dependant					
Dependant					
Dependant					
Dependant					
Dependant					

NAME OF PERSONAL PHYSICIANS	ADDRESS	DATE LAST CONSULTED	REASON AND TREATMENT GIVEN

PART C - MEDICAL QUESTIONNAIRE FOR APPLICANT AND DEPENDANTS

SECTION A - CHECK EACH ITEM YES OR NO. (INSERT ONE TICK PER CHILD)

Have you or any person in this application ever been treated for or ever had any known indication of:

	Yes	No	Yes	No	Yes	No	Yes	No
	EMP		SPOUSE		CHILD		CHILD	
(a) Disorder of eyes, ears, nose or throat?								
(b) Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke, mental or nervous disorder?								
(c) Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis or chronic respiratory disorder?								
(d) Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack or other disorder of the heart or blood vessels?								
(e) Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion or other disorder of the stomach, intestine, liver or gallbladder.								
(f) Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of the kidney, bladder, prostate, or reproductive organs?								
(g) Diabetes, thyroid or other endocrine disorders?								
(h) Gout, neuritis, sciatica, rheumatism, arthritis, or disorder of the muscles or bones, including the spine, back or joints?								
(i) Deformity, lameness, amputation?								
(j) AIDS (Acquired Immune Deficiency Syndrome), ARC (Aids Related Complex) or any other immunological disorder?								
(k) Enlargement of lymph nodes, glands, chronic diarrhoea, unusual skin lesions, cyst, tumor, cancer or unexplained infections?								
(l) Allergies, anaemia, or other disorder of the blood?								
(m) Females only: Are you pregnant? If "YES", How far advanced? _____ months								

PART C (cont'd)

SECTION B - in addition to the conditions listed in SECTION A, to the best of your knowledge and belief has any person named in this application:

	Yes	No	Yes	No	Yes	No	Yes	No
	EMP		SPOUSE		CHILD		CHILD	
(a) Had a check-up, consultation, illness, injury or surgery?								
(b) Had any mental or physical disorder not listed above?								
(c) Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?								

1. **SECTION C** - If you have checked "YES" to any part of SECTION A or SECTION B, please provide complete information regarding diagnosis, symptom(s) or treatment (including all hospitalization, surgery, and diagnostic testing, results) and dates. If more space is needed, attach a separate sheet of paper.

Patient's Full Name	Diagnosis/Symptom	Duration Dates		Details	Recovery *Check only one box.*	
		From	To			
					Full	Partial
					Full	Partial
					Full	Partial
					Full	Partial
					Full	Partial
					Full	Partial

2. Are you or any dependant listed as using or expected to be using medication or serum in the next three months?

INSURED YES ☐ NO ☐ SPOUSE/CHILDREN YES ☐ NO ☐

If you or any dependant listed are currently using medication or serum complete section below.

Name of Person	Name of Drug/Medication or Serum	Monthly cost of Drug/Medication or Serum	Strength of Drug or Medication	Daily Dosage of Drug/Medication or Serum	Length of time on Drug/Medication or Serum

DECLARATION

All applicants must complete

NOTE THE INFORMATION ON THIS FORM IS TO BE CONSIDERED CONFIDENTIAL.

I/We hereby declare that the answers given and recorded herein are, to the best of my/our knowledge, complete and true at this date.

I/We hereby authorize any licensed physician, medical practitioner, hospital, clinic, medical facility or organization which has records of my/our health records of my/our health to release such information to Guardian Life of the Caribbean Limited. A photocopy of this signed authorization shall be as valid as the original.

I/We understand and agree that any injury that occurred on or before the date of this application or any sickness, the signs of which first appeared on or before the date of this application, are not covered by this contract unless fully disclosed on this application. Failure to disclose such information could result in denial of a claim and the cancellation of coverage.

I/We understand and agree that coverage shall not become effective until approved by Guardian Life of the Caribbean Limited.

Signature of Insured ..... Signature of Spouse .....

Dated ...../...../..... (Day / Month / Year) Dated ...../...../..... (Day / Month / Year)