Guardian Group
Guardian Life of The Caribbean Limited

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DECLARATION OF INSURABILITY

GROUP INSURANCE

SECTION 1 – To be completed by the POLICYHOLDER (EMPLOYER)

Name of Policyholder _____ Policy No. _____

Name of Employee or Member _____

Address of Employee or Member _____

Email Address: _____ Contact Number: _____

Employee or Member applying for insurance for ☐ Self ☐ And/Or Dependents

PLEASE COMPLETE A, B, OR C BELOW PERTAINING TO COVERAGE APPLIED FOR BY ANSWERING APPLICABLE QUESTIONS:

A

☐ Initial Coverage

1. Date employee/member considered first eligible for insurance _____
2. Reason coverage not accepted at that time _____

B

☐ Reinstatement of Coverage ☐ Class Change ☐ Certificate No.

1. Has employee/member filed a claim before? ☐ Yes ☐ No. If yes, date filed
2. Date Insurance terminated _____
3. Reason for termination _____

C

☐ Re-establishment of Major Medical Maximum Benefit

1. Employee/member certificate number _____
2. Date last claim filed _____
3. Has patient fully recovered from illness for which last claim filed ☐ Yes ☐ No

SECTION 11 – EMPLOYEE or MEMBER: COMPLETE INFORMATION FOR YOURSELF AND DEPENDENTS

I hereby make application for insurance for myself and/or the following dependents

GIVE FULL NAME	RELATIONSHIP	DATE OF BIRTH	SEX	WEIGHT	HEIGHT	MARITAL STATUS (CHECK ONE)
						☐ Single ☐ Divorced ☐ Married ☐ Legally Separated ☐ Common Law Relationship
						FOR OFFICAL USE ONLY

SECTION 111

A

1. Name and address of your personal physician (if none, kindly state that)
2. Date and reason last consulted
3. What treatment was given or medication prescribed
4. Medical History:
   a) Give details of each sickness or accident for which you have been hospitalized.
   b) Are you actually receiving treatment for any or all of the above sickness or accident mentioned, including prescriptions?

Yes ☐ No ☐

B Have you ever been treated for or ever had any known indication of:	YES	NO	YES	NO	YES	NO	**INSERT ONE TICK PER CHILD**
	EMP		SPOUSE		CHILD		
(1) disorder of eyes, ears, nose or throat?							Details of YES answers: Identify question by number, Circle applicable items, include diagnosis, dates duration and names and address of all atteding Physicians and medical facilities
(2) dizziness, fainting, convulsions, headache, speech defect, paralysis, stroke, mental or nervous disorder?							
(3) Shortness of breath, persistent hoarseness or cough, blood spitting, bronchitis, pleurisy, asthma, emphysema, tuberculosis, or chronic respiratory disorder?							
(4) Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack, or other disorder of the heart or blood vessel?							
(5) jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, divertivulitis, hemorrhoids, recurrent indigestion or other disorder of the stomach, intestine, liver or gall bladder?							
(6) sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of kidney, bladder, prostate or reproductive organs?							
(7) diabetes, thyroid or other endocrine disorders?							
(8) neuritis, sciatica, rheumatism, arthritis, gout or disorder of the muscles or bones including the spine, back or joints?							
(9) deformity, lameness or amputation, or any congenital or acquired physical defects or impairment?							
(10) disorder of skin, lymph glands, cysts, tumor or cancer?							
(11) allergies, anemia, or other disorder of the blood?							
(12) AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or any other Immunological disorder?							
C **Other than the above, have you within the past 5 years** (1) had any mental or physical disorder not listed above?							
(2) had a checkup, consultation, illness, injury or surgery?							
(3) been a patient on a hospital, clinic, sanatorium, or other medical facility?							
(4) had an electrocardiogram, x-ray or other diagnostic test.							
(5) been advise to have any diagnostic test, hospitalization or surgery which was not completed?							
(6) Undergone treatment for alcoholism or drug dependency							
D **Females Only:** (a) Are you now pregnant as far as you know?							
(b) Do you have any gynecological disorder?							

Has any Company or Association ever declined to grant insurance on the person(s) to be considered for insurance or offered a

Modified policy ☐ Yes ☐ No If yes give dates _____

If yes give the name of company _____

Details for questions if any of the answers are yes, give full details below, referring to item numbers above. Use additional sheet if necessary.

NAME	DISEASE OR INJURY	DATE	DETAILS	NAME AND ADDRESS OF PHYSCIAN AND HOSPITAL

I understand and agree that the insurance herein applied for shall not become effective unless and until such insurance shall have been approved for issuance by Guardian Life of the Caribbean Limited at its Home office during the lifetime of the person proposed for coverage and while the health and physical condition of such person remains as represented herein.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health, to give to Guardian Life of the Caribbean Limited, any such information.

I expressly waive on behalf of myself and of any person who shall have or claim any interest in any insurance coverage granted pursuant here to all provisions of law forbidding any physician or hospital official or employee, or other person who has heretofore attended or examined me, or who may hereafter attend or examine me, or who has been or may be consulted by me from disclosing any knowledge or information thereby acquired and from testifying with reference thereto.

A photocopy of this authorization shall be as valid as the original.

Date Completed	Signature of Employee or Member
If person to be considered for insurance is an adult dependent the dependent also signs here →	