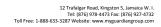


MEMBER ENROLMENT FORM & HEALTH HISTORY QUESTIONNAIRE EB 187





FO	R EMPLOYER USE					
	Div. No.	EMPLOYER/C	COMPANY NAME			
LOCATION		EN	IPLOYMENT DATE	(dd/mm/yyyy) EF	FECTIVE DAT	E* (dd/mm/yyyy) NEW HIRE
						YN
REMARKS						
MEMBER NAME (First) ³		МІ	I ³ (Last) ³			
MEMBER No. ¹						
OCCUPATION						
DATE OF BIRTH PROOF OF AGE Birth Certificate attached Other GENDER M F MARITAL STATUS* Ma Si Di Wi Se Co						
*Ma _ Married; Si - Single; Di - Divorced; Wi - Widowed, Se - Separated, Co - Common law RN 2 Home Tel. No.						
HOME ADDRESS						
E-mail Address						
GROUP HEALTH ONLY						
DEPENDENTS		1 254				
SURNAME	FIRST NAME	MI SEX	RELATIONSHII	P DATE OF	BIRTH	TRN
	i	M F				
		M F				
		M F				
		M F				
	GROUP LIFE, GI		SONAL ACCIE	DENT & PENSIC	N ONLY	
SALARY P.A.						
PENSION CONTRIBUTION: BASIC (5% of pensionable salary)						
TRUSTEE — If the designated beneficiary is a m						
BENEFICIARY NAME	RELATIONSHIP	LIFE (%)		mm/yyyy)	SEX	TRN
					M F	
TRUSTEE NAME:	1			<u></u>		
					M F	
TRUSTEE NAME:				T ₌	<u>1</u>	
					M F	
TRUSTEE NAME:				T ₌	I	
					M F	
TRUSTEE NAME:				I _		
TRUSTEE NAME:					M F	
	. Politica demand	· · · · · · · · · · · · · · · · · · ·	· · · / have a	9 11.V - d - d-	•	· · · · · · · · · · · · · · · · · · ·
I elect coverage on behalf of myself contributions required (if any) for the		dent(s) as listed	l above (where a	pplicable) and autno	rize my emp	ployer to deduct from my earnings th
I authorize Guardian Life Limited, wh	ere applicable, to have a	access to, and c	opies of, all medic	cal, hospital or other	institution/a	agency records relating to the diagnosi
treatment or services provided to me of						
SIGNATURE OF EMPLOYEE						DATE
NAME OF AUTHORIZED OFFICER OF E	MPLOYER SIGNA	ATURE OF AUTH	ORIZED OFFICER OI	F EMPLOYER	POSITION	OF AUTHORIZED OFFICER OF EMPLOYER
COMPANY STAMP						DATE

(If employee is applying for coverage outside of eligibility period, please complete the Health History Questionnaire on the overleaf)