Guardian Group
Guardian Life Limited

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Toll Free: 1-888-633-3287 Website: www.myguardiangroup.com

Guardian HEALTH

MEMBER ENROLMENT FORM & HEALTH HISTORY QUESTIONNAIRE EB 187

FOR EMPLOYER USE

POLICY No. | Div. No. | EMPLOYER/COMPANY NAME

LOCATION | EMPLOYMENT DATE (dd/mm/yyyy) | EFFECTIVE DATE* (dd/mm/yyyy) | NEW HIRE Y N

REMARKS

MEMBER NAME (First) [3] | MI [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

TRN [2] | Home Tel. No.

Work Tel. No. | Cellular No.

HOME ADDRESS

E-mail Address

GROUP HEALTH ONLY

DEPENDENTS

SURNAME	FIRST NAME	MI	SEX	RELATIONSHIP	DATE OF BIRTH	TRN
			M F			
			M F			
			M F			
			M F			
			M F			

GROUP LIFE, GROUP PERSONAL ACCIDENT & PENSION ONLY

SALARY P.A.

PENSION CONTRIBUTION: BASIC (5% of pensionable salary) % VOLUNTARY %

TRUSTEE – If the designated beneficiary is a minor, you are required to appoint a trustee who will manage the insurance proceeds on behalf of the minor. The trustee may be any competent adult or institution.

BENEFICIARY NAME	RELATIONSHIP	LIFE (%)	PENSION (%)	DATE OF BIRTH (dd/mm/yyyy)	SEX	TRN
					M F	
TRUSTEE NAME:						
					M F	
TRUSTEE NAME:						
					M F	
TRUSTEE NAME:						
					M F	
TRUSTEE NAME:						
TRUSTEE NAME:					M F	

I elect coverage on behalf of myself and my eligible dependent(s) as listed above (where applicable) and authorize my employer to deduct from my earnings the contributions required (if any) for the coverage.

I authorize Guardian Life Limited, where applicable, to have access to, and copies of, all medical, hospital or other institution/agency records relating to the diagnosis, treatment or services provided to me or a covered dependent.

SIGNATURE OF EMPLOYEE

DATE

NAME OF AUTHORIZED OFFICER OF EMPLOYER

SIGNATURE OF AUTHORIZED OFFICER OF 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)

HEALTH HISTORY QUESTIONNAIRE

All information contained in this questionnaire is strictly confidential.

This Health History Questionnaire is being completed for: EMPLOYEE ONLY ☐ EMPLOYEE & DEPENDENTS ☐ DEPENDENTS ONLY ☐

NAME	RELATIONSHIP	HEIGHT	WEIGHT	DATE OF BIRTH (dd/mm/yyyy)	SEX	TRN
					M F	
					M F	
					M F	
					M F	
					M F	

PERSONAL HEALTH HISTORY

(NOTE: IF QUESTIONNAIRE IS BEING COMPLETED FOR NEW DEPENDENTS, GIVE DETAILS ONLY FOR DEPENDENTS.)

FOR THE EMPLOYEE — YES / NO

1. Are you employed by the employer named on this form for more than 30 hours every week? ☐ ☐

FOR THE EMPLOYEE AND/OR DEPENDENTS KINDLY RESPOND 'YES' OR 'NO' TO THE FOLLOWING QUESTIONS.

2. During the last 5 years, have you or any of your dependents consulted, been examined or treated by a Doctor, or been advised to have any diagnostic tests (e.g. blood tests, X-Rays, CAT Scan, MRI) etc.? ☐ ☐
3. During the last 5 years, have you or any of your dependents undergone a surgical operation, or been treated in any hospital or other institution? ☐ ☐
4. Have you or any of your dependents been treated for, or been told that you have Heart Trouble, Blood Disease, High Blood Pressure, Kidney Disorder, Diabetes, Tuberculosis, Cancer, Tumor, Ulcer, Asthma, Epilepsy, Alcoholism, Mental Disorder, or any other disease not listed anywhere on this application? ☐ ☐
   (If 'Yes' underline/state disease.)
5. Have you or any of your dependents been diagnosed with, or treated for HIV, AIDS, or ARC (AIDS related complications) (If 'Yes; underline disease.) ☐ ☐
6. Are you or any of your dependents now receiving, contemplating, or been advised to seek any medical attention or surgical treatment, or taking any medication? ☐ ☐
7. Do you or any of your dependents have any disorder of the female organs or breast? ☐ ☐
8. Are you or any of your dependents now pregnant? ☐ ☐
9. Do you or any of your dependents have any physical impairments? ☐ ☐
10. Do you or any of your dependents have any prior or existing history of alcoholism or drug abuse? ☐ ☐
11. Have you or any of your dependents ever had an application for Life or Health Insurance declined, postponed, rated or modified in any way? ☐ ☐

IF THE RESPONSE TO ANY OF QUESTIONS 2-11 IS 'YES', GIVE COMPLETE DETAILS BELOW (CONTINUE ON ANOTHER SHEET, IF NECESSARY)

QUES-TION NO.	DATE OF ILLNESS	FULL NAME OF PERSON TREATED	NATURE OF AILMENT	DEGREE OF RECOVERY: (FULL, PARTIAL OR CONTINUING)	NAME AND ADDRESS OF ATTENDING PHYSICIAN OR DENTIST

I declare that all the statements on this form are full, true and complete, and I understand that they form the basis upon which any insurance will be made effective. I authorize the physician, hospital or other medically related facility to disclose to **Guardian Life Limited** information about my health, habits or medical history, as well as that of any dependents listed above. It is further understood that **Guardian Life limited** reserves the right to request an examination by a Physician of their choice to aid its decision.

Signature of Employee _____ **Date** _____

TO BE COMPLETED BY THE EMPLOYER (When the questions relate to the employee)

	YES	NO	If YES give details
1. Is the employee absent from work and unable to perform his/her duties?	☐	☐	
2. Has the employee been absent from work for more than 1 week due to sickness or injury during the past 6 months?	☐	☐	
3. Do you know of any prior or existing serious physical impairment, history of drug abuse or alcoholism?	☐	☐	

NAME OF AUTHORIZED OFFICER OF EMPLOYER _____

SIGNATURE OF AUTHORIZED OFFICER OF EMPLOYER _____

POSITION OF AUTHORIZED OFFICER OF EMPLOYER _____

DATE _____

For Official Use Only: Index Member No., TRN & Name of Member