

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

POLIC Guardian Life of The Caribbean Limited

	PART A - GENERAL INFORMATION	L INFORMATION				
POLICY HOLDER						
Address			Busines	Business Telephone No.	0.	
INSURED:			DATE E	EMPLOYED:		
MARITAL STATUS	Single Married		Home Te	Home Telephone No.	A COLUMN TO THE PROPERTY OF TH	
	PART B - PERSONS TO BE	S TO BE COVERED		The state of the s		
Provide first name of insured and	Provide first name of insured and all family members to be covered plus last name of any member if different from the insured's	e of any member if diffe	erent from the	insured's		
LAST NAME	FIRST NAME	SEX BIRTH DATE	DATE	AGE	HEIGHT	WEIGHT
Insured						
Spouse	Table 1					
Dependant						
Dependant	in the state of th					
Dependant	· · · · · · · · · · · · · · · · · · ·					
Dependant	To Address of the Control of the Con	Amazar Araba (Amazar Araba				
Dependant	AND THE PROPERTY OF THE PROPER					
Dependant					05000	
NAME OF PERSONAL PHYSICIANS	ADDRESS	DATE LAST	AST LTED	REASON AND	ID TREATMENT	ENT GIVEN
	AND THE REPORT OF THE PROPERTY		The state of the s	TATALON DE LA CONTRACTION DEL CONTRACTION DE LA	espiratorismastoris (sedente de la constante d	an i se se se na se
	PART C - MEDICAL QUESTIONNAIRE FOR APPLICANT AND DEPENDANTS	E FOR APPLICANT	AND DEPEN	NDANTS	histories annies an	anticerate agrant passantant and assecting
SECTION A - CHECK EACH IT	SECTION A - CHECK EACH ITEM YES OR NO. (INSERT ONE TICK PER CHILD)	R CHILD)		The state of the s		
any known indication of: (a) Disorder of eyes, ears, nose or throat?	any known indication of: (a) Disorder of eyes, ears, nose or throat?	•	Yes No EMP	SPOUSE No	Yes No	Yes No
(b) Dizziness, fainting, convulsions or nervous disorder?	(b) Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke, mental or nervous disorder?	, mental				
(c) Shortness of breath, persistent pleurisy, asthma, emphysema, t (d) Chest pain, palpitation, high bloattack or other disorder of the h	(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?	eart .				
 (e) Jaundice, intestinal bleeding, ulcer, hernia, apperent indigestion or other disorder of the ston recurrent indigestion or other disorder of the ston (f) Sugar, albumin, blood or pus in urine, venereal disobladder, prostate, or reproductive organs? (g) Diabetes, thyroid or other endocrine disorders? 	 (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? 	emorrhoids, Ider. I the kidney,				
(h) Gout, neuritis, sciatica, rheumatism the spine, back or joints?(i) Deformity, lameness, amputation?	(h) Gout, neuritis, sciatica, rheumatism, arthritis, or disorder of the muscles or bones, including the spine, back or joints?(i) Deformity, lameness, amputation?	nes, including				
(i) AIDS (Acquired Immune Deficie immunological disorder? (k) Enlargement of lymph nodes, glicancer or unexplained infections.	 (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? 	or any other cyst, tumor,				
(I) Allergies, anaemia, or other disorder of the blood?	order of the blood?					
(m) Females only: Are you pregnant? If "YES",	How far advanced? m	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:

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 I/We hereby authorize any licensed physician, medical practitioner, hospital, clinic, medical facility or organization which has records of my/our health to release such information to Guardian Life of the Caribbean Limited. A photocopy of this signed 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 NOTE THE INFORMATION ON THIS FORM IS TO BE CONSIDERED CONFIDENTIAL. I/We understand and agree that any injury that occured 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. (c) Been advised to have any diagnostic test, hospitalization, surgery which was not completed? authorization shall be as valid as the original. (b) Had any mental or physical disorder not listed above? (a) Had a check-up, consultation, illness, injury or surgery? Signature of Insured I/We understand and agree that coverage shall not become effective until approved by Guardian Life of the Caribbean Limited If you or any dependant listed are currently using medication or serum complete section below. Are you or any dependent listed as using or expected to be using medication serum in the next three months? separate sheet of paper. Name of Person Patient's Full Name Diagnosis/Symptom Name of Drug/Medication or Serum All applicants must complete ٥ From DECLARATION **Duration Dates** Monthly cost of Drug/Medication Siganture of Spouse or Serum 5 Dated Day ੁ Strength of Drug or Medication YES. Yes No EMP INSURED Details Yes | No NO Dally Dosage of Drug/Medication or Serum LYSS NO LYSS NO. YES SPOUSECHILDREN 윒 Check only one box.
Full Partial Length of time on Drug/Medication Recovery T Ī Ī Ē Ī or Serum Š CHILD Partial Parlia Partia Partia

Dated ...

Month