

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

Guardian Life of The Caribbean L	imited	DECLARATIO	ON OF INS	URABII	LITY								
		PART A - GENE	RAL INFO	RMATIC	NC								
POLICY HOLDER													
Address					Business Telephone No.								
INSURED:					DATE EMPLOYED:								
MARITAL STATUS Single Married					Home Telephone No.								
		PART B - PERSO	ONS TO BE	COVE	RED								
Provide first name of insured an	d all family members	to be covered plus last n	ame of any r	nember i	f differen	t from the	nsured's						
LAST	ГИАМЕ	FIRST NAME	SEX	BIR	TH DAT	E	AGE HEIGHT N		WEIG	SHT			
Insured								\top					
Spouse												ы	
Dependant													
Dependant													
Dependant													
Dependant													
Dependant													
Dependant								\top					
NAME OF PERSONAL ADDRESS PHYSICIANS					DATE LAST REASON AND TREATME				:NT GI	VEN			
	2							9					
	PART C - MED	DICAL QUESTIONNAI	RE FOR A	PPLICA	NT AN	D DEPEN	DANTS						
SECTION A - CHECK EACH	ITEM YES OR NO.	(INSERT ONE TICK F	PER CHILD)									
	application ever bee	en treated for or ever h	nad		Ve	s No	Voc	No I	Voc	No	Voc	No	
Market Service Company						27.72.72		_					
a) Disorder of eyes, ears, nose of	or throat?												
Dizziness, fainting, convulsior or nervous disorder?	e you or any person in this application ever been treated for or ever had known indication of: Yes No Yes No Yes No Yes No Hobbit No Service N												
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?												71	
e) Jaundice, intestinal bleeding, ulcer, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion or other disorder of the stomach, intestine, liver or gallbladder.													

SPOUSE	CHILD	CHILD					
	5						
		:=: \					
	SPOUSE	SPOUSE CHILD					

(m) Females only:

the spine, back or joints?
(i) Deformity, lameness, amputation?

bladder, prostate, or reproductive organs?
(g) Diabetes, thyroid or other endocrine disorders?

(I) Allergies, anaemia, or other disorder of the blood?

Are you pregnant? If "YES", How far advanced?_

(f) Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of the kidney,

(h) Gout, neuritis, sciatica, rheumatism, arthritis, or disorder of the muscles or bones, including

(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?

PART C (cont'd) SECTION B - in addition to the	conditions listed in SE	CTION A	to the hes	t of you	r knowled	ide and h	nelief h	ias anv	narso	n nam	ed in	
this application:	Conditions listed in Sc	CHON A,	, to the bea	t or you	6	No	Yes				Yes	No
						EMP	_	USE		IILD		HILD
(a) Had a check-up, consultation, illn	00 NE 1870 EN 1851			*								
(b) Had any mental or physical disor												
(c) Been advised to have any diagno surgery which was not completed						+		-				
SECTION C - If you have check symptom(s) or treatment (incluse separate sheet of paper.												
Patient's Full Name												
From To						Dotalio						hov
		FIOIL	10	-				Check o		Partial		
										ANOT		
										Fi	ıll	Partial
										Fı		Partial
										F	ıll	Partial
										F	ااد	Partial
										F	ااد	Partial
serum in the next three month	are currently using medi	cation or			YES[mental .	NO 🗌		YE		NO	
Name of Person Drug/Medication or Serum							Daily Dosage of Drug/Medication or Serum			Length of time on Drug/Medication or Serum		
-							+-			-		
												\neg
							-			-		
		l										
							1			\vdash		\neg
							+-			₩		
	All		.ARATION									
NOTE THE INFORMATION ON	THIS FORM IS TO BE C	ONSIDER	RED CONFII	DENTIA	L.							
I/We hereby declare that the a	nswers given and reco	rded here	in are, to t	he best	of my/ou	r knowle	dge, c	omplet	e and	true at	this o	late.
I/We hereby authorize any lice my/our health records of my/o authorization shall be as valid	ur health to release su											
I/We understand and agree th appeared on or before the dat disclose such information cou	e of this application, a	re not co	vered by th	nis cont	ract unle	ss fully o						
I/We understand and agree that coverage shall not become effective until approved by Guardian Life of the Caribbean Limited.												

Siganture of Spouse

Signature of Insured

Dated/.../.../ Day Month Year