

PLEASE COMPLETE IN BLOCK LETTERS

## GROUP HEALTH AND LIFE APPLICATION FORM

POLICY NO. LIFE \_\_\_\_\_\_ POLICY NO. HEALTH \_\_\_\_\_

GI0001 - V.1/10-2016

	SECTION A	A-APPLICAI	NT INFORMATION		Ngaragagag Segilah 2 (b) 142		
NAME OF POLICYHOLDER:				<u>-</u> "			
NAME OF EMPLOYEE/INSURED:					DATE OF BI	RTH:(dd/mm/yyyy	)
EMAIL ADDRESS:					GENDER:	☐ MALE	FEMALE
TELEPHONE (Home):	Ext:		(Cellular):				
MARITAL STATUS: ☐ Single ☐ Married	l 🔲 Common La	w Div	orced 🔲 Widow				
IDENTIFICATION (tick one) DP PP I (Please attach a copy) Number:	RAGE:	JFE .	EXTRA COVERAGE:(if applicable)  VOLUNTARY LIFE DEPENDENT LIFE				
	SECTION B	- CO-ORDINA	ATION OF BENEFI	ÍS A	destrues corrigio		Library Library
1. Are you or your spouse covered by any o	ther Medical or Hea	aith Plan? 🔲	Yes 🔲 No	, , , , , , , , , , , , , , , , , , ,			The state of the s
If Yes, please give (a) NAME OF PLAN:		(b)	NAME OF INSURAN	ICE CON	IPANY:		
	ECTION C - EMPL	OYEE'S DEP	ENDENTS TO BE C	OVERE	D Comment		
RELATIONSHIP NAME OF DEPEND	ENT/S	GENDER (M/F)			FECTIVE DATE COUNTRY OF RI		OF RESIDENCE
SPOUSE							
CHILD							
CHILD							
CHILD							
CHILD							
A school letter is required every academic yea							
SECTION D	- BENEFICIARY IN	FORMATION	I (APPLICABLÉ TO	GROUI	P LIFE ONLY		
RELATIONSHIP NAME OF BENEFIC	CIARY	GENDER DATE OF BIRTH (M/F) (dd/mm/yyyy)		PERCENTAGE (%)			
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	ON E - ACCOUNT	INFORMAT	ION FOR PAYMEN	T OF C	LAIMS	propried States	E Estelás do Aco
ACCOUNT NUMBER: (confirm with copy of ban	k statement)		NAME OF BANK:				
ACCOUNT TYPE: SAVINGS CHEQU	ING		NAME OF BRANCH	:			
I hereby apply for Registration as a Member of t. made by the Policyholder for contributions requir conditions of the Plan and agree to be bound ther Guardian Life of the Caribbean Limited.	ed to be paid by me	in accordance	with the terms and a	ondition:	s of the Plan. I	am familiar with	the terms and
EMPLOYEE SIGNATURE:		DATE: (dd/mm/yyyy)					
SECTION F = F	OR OFFICIAL USE	ONLY (TO B	E COMPLETED BY	THEPO	DLICYHOLDE	R)	
DATE EMPLOYED: (dd/mm/yyyy)  DATE OF CONFIRMATION: (dd/mm/yyyy)					EFFECTIVE DATE OF COVERAGE: (dd/mm/yyyy)		
COVERAGE TIER: (tick as applicable)  SINGLE   EMPLOYEE + ONE	,	IF GROUP LIFE, EMPLOYEE ANNUAL SALARY: BD\$					
PLAN ADMINISTRATOR:				PLACE	COMPANY ST	TAMP HERE:	
NAME: SIG	NATURE:						
DATE : (dd/mm/yyyy)							



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

		PART A - GENE	RAL INFO	RMATION		<u></u>	Managagagagagagagagagagagagagagagagagaga	and the second s	
POLICY HOLDER			ή				and the same of th	, a (1998)	
Address					Busine	Business Telephone No.			
INSURED:						DATE EMPLOYED:			
MARITAL STATUS	Single		arried	- 48-465apan		Telephone No			
		PART B - PERSO	ONS TO BE	COVERED					
Provide first name of insured and	all family member	s to be covered plus last n	ame of any n	nember if differer	nt from th	e insured's	***************************************	anni da da sa	
LAST	NAME	FIRST NAME	SEX	BIRTH DA	ΓE	AGE	HEIGHT	WEIGHT	
Insured					· i=i=				
Spouse									
Dependant									
Dependant									
Dependant									
Dependant									
Dependant		_							
Dependant	<u>,</u>	• tribbelly/ananos.					Paul Previous de Liena		
NAME OF PERSONAL PHYSICIANS		ADDRESS	and the second	DATE LAST CONSULTED REASON AND TREATME			ENT GIVEN		
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						', <u>d</u>			
	PART C - ME	DICAL QUESTIONNA	IRE FOR A	PPLICANT AN	D DEPE	NDANTS			
SECTION A - CHECK EACH ITH Have you or any person in this ap				_	a i Ni	Vac	Vac Na	£ 3.5	

any known indication of:

- (a) Disorder of eyes, ears, nose or throat?
- (b) Dizziness, fainting, convulsions, headache, speech defect, paralysis or stroke, mental or nervous disorder?
- (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?
- (e) Jaundice, intestinal bleeding, ulcer, hemia, 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?
- (h) Gout, neuritis, sciatica, rheumatism, arthritis, or disorder of the muscles or bones, including the spine, back or joints?
- (i) Deformity, lameness, amputation?
- (j) AIDS (Acquired Immune Deficiencý 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?
- (I) Allergies, anaemia, or other disorder of the blood?

(m) Females only:		
Are you pregnant? If "YES",	How far advanced?_	months

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PART C (cont'd)								
SECTION B - in addition to th	e conditions listed in SE	ECTION A	$\lambda$ , to the bes	t of you	r knowledge and l	bellef has any	person nam	ied in
this application:					Yes No EMP	Yes No	Yes No	
(a) Had a check-up, consultation, illi					CIAL	STOUSE 1	CHILD	CHILD
<ul><li>(b) Had any mental or physical disc</li><li>(c) Been advised to have any diagn</li></ul>								To the same of the
surgery which was not complete	d?							
SECTION C - If you have che symptom(s) or treatment (included) separate sheet of paper.	cked "YES" to any part of uding all hospitalization, s	f SECTIC surgery, a	ON A or SECT and diagnosti	TION B. c testing	piease provide con g, results) and date	mplete informa s. If more spa	tion regardin ce is needed	g diagnosis, attach a
Patient's Full Name	Diagnosis/Symptom	Durati	on Dates		Details		Q.	covery
District services		From	To		Z O LUNG		Ě	only one box.
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Are you or any dependant I serum in the next three month  If you or any dependant listed	15?		serum comp	lete sed	YES	моП	SPOUSE/C	HILDREN NO[]
Name of Person	Name of Person Drug/Medication or Serum		Monthly cos Drug/Medica or Serur	ation 🛔	Strength of Drug or Medication	Daily Dosag Drug/Medica or Serum	ition Drug	h of time on Medication Serum
KITEGE PRINSERS				Avor Craid Ca				- A Proposition
				A CONTRACTOR OF THE PERSONS ASSESSMENT				
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NOTE THE INFORMATION ON	THIS FORM IS TO BE C	ONSIDEF	RED CONFID	ENTIA	L,			
I/We hereby declare that the a	inswers given and recor	ded here	ein are, to th	e best	of my/our knowle	dge, complete	and true at	this date.
i/We hereby authorize any lico my/our health records of my/o authorization shall be as valid	our health to release suc	al practi ch inforn	tioner, hosp nation to Gu	ital, cli ardian	nio, medical facili Life of the Caribb	ity or organiz: ean Limited. <i>i</i>	ation which   A photocopy	has records of of this signed
I/We understand and agree th appeared on or before the da disclose such information cou	te of this application, a	re not co	vered by th	is cont	raci unless fully d	er any sicknes lisclosed on t	s, the signs his applicat	of which first ion. Failure to
I/We understand and agree th	at soverage shall not b	ecome el	ffective unti	l appro	ved by Guardian L	ife of the Car	ibbean Limit	ed.
Signature of Insured		•,••••••	Sigantı	ire of S	pouse	***************************************		

Dated \_\_\_\_\_/\_\_\_/ Day Month Year

Dated ...... Day

.../.../ Month Year