Guardian Group
Guardian Life of The Caribbean Limited

STANDARD HEALTH INSURANCE CONTRACT
HEALTH INSURANCE APPLICATION FORM

NOTE THE INFORMATION ON THIS FORM IS TREATED AS CONFIDENTIAL

Please check the appropriate boxes:

☐ Individual Coverage ☐ Group Coverage

☐ Employed ☐ Unemployed ☐ Self Employed ☐ Retired

Proposed Effective Date of Policy _____

PART A: Applicant Information

	Last First Middle	Date of Birth Day / Month / Year	Sex M/F	Height Feet/Inches	Weight Lbs/Oz	Immigration Status
Applicant						

Postal Address:_____ Email Address_____

Physical Address:_____

Telephone: _____ Fax: _____

Beneficiary: _____ Relationship: _____

Beneficiary Date of Birth: _____

Day / Month / Year

Postal Address/Telephone: _____

PART B: Employer Information

Name of Employer: _____ Employer #:_____

Postal Address: _____ Email Address: _____

Physical Address: _____

Telephone: _____ Fax: _____

Employer's signature: Date: _____

Relationship	Family Members Names Last First Middle	Date of Birth Day / Month / Year	Sex M/F	Height Feet/Inches	Weight Lbs/Oz	Immigration Status
Spouse						
Child 1/ Dependent Offspring						
Child 2/ Dependent Offspring						
Child 3/ Dependent Offspring						

Is your spouse employed? Y / N. If yes, please provide name of employer:_____

Are medical benefits available from any other approved insurer to any person listed above (Part A &/or Part C)? Y / N. If yes, please provide name of approved insurer and telephone information:

Approved Insurer: _____ Telephone: _____

Has any person listed above (Part A &/or Part C) had continuous coverage for a period of not less than one year? Y/N. If yes, please

state the name of the approved insurer: _____

Part D: Medical Questionnaire
Must be completed by all persons

In the last twelve months has any person listed above (Part A &/or Part C) ever been advised to or received medical consultation, care, treatment or taken medication in relation to any of the following:

1. Y / N Heart or circulatory system (including but not limited to infarction, heart attack, angina, rheumatic fever, cardiac defect, arrhythmias, diseases of veins, arteries or valves, stroke) and/or any other symptom regarding circulatory system or heart.

2. Y / N Sexually transmitted diseases or Human Immunodeficiency Virus (HIV) or Acquired lmmuno Deficiency Syndrome (AIDS) or ARC (AIDS related complex).

3. Y / N Neurological System (including but not limited to convulsions epilepsy, paralysis, Multiple Sclerosis, cerebral infarction (stroke), Alzheimer's disease, dementia) and/or any other symptom regarding the neurological system, which if referred to a doctor would result in a diagnosis.

4. Y/ N Liver disorders (including but not limited to fatty liver, cirrhosis, hepatitis) and/or any other symptom regarding the liver, which if referred to a doctor would result in a diagnosis.

5. **Y/** N Kidney/Renal disease or failure

In the last twelve months has any person listed above (Part A &/or Part C) ever:

6. Y/ N Been treated for Cancer, if yes, please explain:

_____

7. Y/ N Been treated for Diabetes(sugar)/Hypertension(high blood pressure) , if yes, please explain:

_____

8. Y/ N Been treated for Respiratory conditions, if yes, please explain:

_____

9. Y / N Had an organ Transplant, if yes please explain:

_____

10. Y/ N Had major surgery, if yes please explain:

_____

11. Y/N Are you currently on medications? Please specify.

_____

12. Females only: Are you pregnant, if yes please specify the number of weeks gestation:

_____

Has any approved insurer within the last twelve months:

13. Y/N Declined an application for health insurance?

14. Y/N Required an increased premium or imposed special condition?

15. Y/N Cancelled or refused to renew an existing health insurance policy

Declaration

I hereby declare that the answers given and recorded herein are, to the best of my/our knowledge, complete and true as at this date.

I hereby authorize any registered medical practitioner, healthcare facility or approved insurer which has copies of my health records to release such information to (name of approved insurer). A photocopy of this signed authorization shall be as valid as the original.

I understand and agree that any injury that occurred within twelve months 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.

I understand and agree that coverage shall not become effective until accepted by the approved insurer.

I understand that any changes in my health status after submission of application and prior to approval of coverage must be reported to the approved insurer.

Signature of Applicant: _____ Signature of Dependent (if applicable) _____

Date: _____
DD/MM/YY

THIS APPLICATION WILL BE VALID FOR 30 DAYS FROM THE DATE OF SIGNATURE.

For Official **Use** Only Comments from Approved Insurer

FAILURE TO DISCLOSE RELEVANT DETAILS OR GIVING MISLEADING INFORMATION MAY CAUSE YOUR APPLICATION TO BE DEEMED NULL AND VOLD".