Guardian Group
Guardian Life Limited

MEMBER ENROLMENT FORM & HEALTH HISTORY QUESTIONNAIRE EB 187

Guardian HEALTH

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

FOR EMPLOYER USE

POLICY No.:	DIV. NO.:	EMPLOYER/COMPANY NAME:	LOCATION:

EMPLOYMENT DATE	EFFECTIVE DATE	NEW HIRE:	REMARKS:
DD / MM / YYYY	DD / MM / YYYY	☐ YES ☐ NO	

EMPLOYEE INFORMATION

MEMBER NAME: FIRST / MI / LAST | MEMBER NO.:

OCCUPATION: | DATE OF BIRTH: DD / MM / YYYY | PROOF OF AGE: ☐ Birth Cert. attached ☐ Other

GENDER: ☐ M ☐ F | MARITAL STATUS: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Common Law | TRN:

TELEPHONE NO.: (H): (W): (C): | E-MAIL ADDRESS:

ADDRESS:

ELECTRONIC FUNDS TRANSFER INFORMATION

BANK NAME: | BANK ADDRESS: | BRANCH: | ACCOUNT NO.:

ACCOUNT NAME(S): | ACCOUNT TYPE: ☐ Savings ☐ Chequing

☐ I confirm that the information provided above is correct and as such Guardian Life Limited will not be held responsible for any errors in the information I completed, resulting in the transfer of funds to an incorrect account.

GROUP HEALTH ONLY

[Continue on additional sheet, if necessary]

DEPENDENTS

SURNAME	FIRST NAME	MI	SEX	RELATIONSHIP	DATE OF BIRTH (DD | MM | YYYY)	TRN
			☐ M ☐ F		| |	
			☐ M ☐ F		| |	
			☐ M ☐ F		| |	
			☐ M ☐ F		| |	

GROUP LIFE, GROUP PERSONAL ACCIDENT & PENSION ONLY

[Continue on additional sheet, if necessary]

SALARY P.A.: $ | PENSION CONTRIBUTION: | BASIC (5% of pensionable salary) ______% | VOLUNTARY ______%

Please Note: A trustee must be appointed for beneficiaries under 18 years of age. The trustee may be any competent adult or institution, who will manage the insurance proceeds on behalf of the minor.

BENEFICIARY NAME	RELATIONSHIP	LIFE (%)	PENSION (%)	DATE OF BIRTH (DD | MM | YYYY)	SEX	TRN	TRUSTEE NAME (WHERE APPLICABLE)
				| |	☐ M ☐ F		
				| |	☐ M ☐ F		
				| |	☐ M ☐ F		
				| |	☐ M ☐ F		

AUTHORIZATION, DECLARATION AND CONSENT

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.

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.

I certify the information above to be true and correct, and understand that this data once accepted may be used to update our records. I hereby authorize Guardian Life Limited to obtain independent verification of any information provided.

I agree that my client data may be shared with Guardian Life's group corporate structure which includes its parent company, subsidiaries, associated and affiliated companies of its ultimate parent company as well as with credit bureaus and regulators in and outside of the jurisdictions in which Guardian Life Limited operates in order to assist with providing accurate and up to date services, offering products and services and marketing other products and services to me and I waive the rights of confidentiality in that regard.

____
SIGNATURE OF EMPLOYEE

DATE: _____ / _____ / _______
DD MM YYYY

____
NAME OF AUTHORIZED OFFICER OF EMPLOYER

____
SIGNATURE OF AUTHORIZED OFFICER OF EMPLOYER

____
POSITION OF AUTHORIZED OFFICER OF EMPLOYER

____
COMPANY STAMP

DATE: _____ / _____ / _______
DD MM YYYY

(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.

[Continue on additional sheet, if necessary]

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.

Question	YES	NO
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/state 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 additional sheet, if necessary]

QUEST. NO.	DATE OF ILLNESS (DD | MM | YYYY)	FULL NAME OF PERSON TREATED	NATURE OF AILMENT	DEGREE OF RECOVERY: (FULL, PARTIAL OR CONTINUING)	NAME AND ADDRESS OF ATTENDING PHYSICIAN OR DENTIST
	| |				
	| |				
	| |				
	| |				

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 (DD/MM/YYYY): _____ / _____ / ______

Form # EB.E 0007/00187 03/2010; 07/2014; 11/2016; 01/2017; 03/2018; 10/2022