Northeast Regional Office
PO Box 26040
Lehigh Valley PA 18002-6040

Midwest Regional Office
PO Box 8012
Appleton WI 54912-8012

Western Regional Office
PO Box 2454
Spokane WA 99210-2454

Evidence of Insurability for Group Insurance (2-50 Lives)

Please complete in ink. Erasures and changes invalidate this form.

1. Employee: 2. Employer: 3. Group Plan #: **G-**

4. Eligible dependents if proposed for coverage **Spouse** ☐ Yes ☐ No Date of Marriage mo. day yr. **Child(ren)** ☐ Yes ☐ No

5. Home Address:

6. Date of Full Time Employment: 7. Occupation: 8. Annual Earnings:

9. Do you actively work full time for full pay at least 30 hours weekly, year round for the above named employer? ☐ Yes ☐ No

10. Social Security Number: 11. Sex: ☐ Male ☐ Female

12. Beneficiary Name (last, first, middle) and relationship:

13. Give full name of each person (last, first, middle)	Place of Birth	Date of Birth: mo./day/yr.	Height: ft./in.	Weight: lbs.
Employee				
Spouse				
Children (1)				
(2)				
(3)				

The following questions (14-20) must be answered for **ALL** individuals (Employee, spouse and child(ren) for whom coverage is being requested. If any question is answered "Yes", please provide details in the additional space provided.

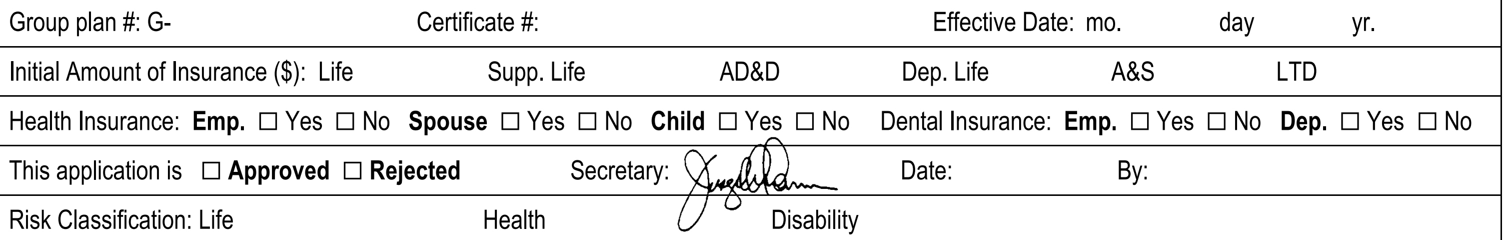
14. Used tobacco in the last 12 months? ☐ Yes ☐ No

15. Ever applied to Guardian for insurance? ☐ Yes ☐ No If "Yes", list plan/policy number:

16. Is any individual currently pregnant? ☐ Yes ☐ No Who? ______________________
Due Date: _____ / _____ / _____ Multiple fetuses? ☐ Yes, Number _____ ☐ No Complications (current or past)? ☐ Yes ☐ No
Details if "Yes": ______________________

17. Has any individual ever been diagnosed with or treated for HIV, AIDS or AIDS-Related Complex?	☐ Yes ☐ No
18. In the past 24 months, has any individual been advised to have treatment or been treated for drug abuse, chemical dependency or alcohol abuse?	☐ Yes ☐ No
19. In the past 24 months, has any individual been diagnosed with, treated for, or is any individual currently suffering from any of:	
a. Heart Disease, Stroke, High Blood Pressure, Elevated Cholesterol, Heart Murmur, Varicose Veins	☐ Yes ☐ No
b. Asthma, COPD, Respiratory Disease, Sleep Apnea, Migraines, Epilepsy, Paralysis, Cerebral Palsy, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS)	☐ Yes ☐ No
c. Depression, Anxiety, ADD/ADHD, Bipolar Disorder, Schizophrenia, Brain or Spinal Cord Injuries	☐ Yes ☐ No
d. Cancer, Tumor, Lumps, Growths, Kidney Disease, Kidney Failure	☐ Yes ☐ No
e. Diabetes, Hepatitis, Liver Disease, Hyperthyroidism, Lupus (Systemic or Discoid), Blood or Bleeding Disorders	☐ Yes ☐ No
f. Prostate Disorder, Infertility, Endometriosis, Ulcerative Colitis, Crohn's Disease	☐ Yes ☐ No
g. Arthritis (osteo or rheumatoid), Herniated disc, Torn ACL/meniscus of knee	☐ Yes ☐ No
h. Any condition requiring or potentially requiring an organ transplant	☐ Yes ☐ No
20. In the past 24 months, has any individual applying for coverage been or been advised to be hospitalized, had or been advised to have surgery or diagnostic testing, or currently taking any prescription medications?	☐ Yes ☐ No

Please provide details for all "Yes" answers. If more space is needed, attach a separate page giving full details, sign and date each page.						
Question Number	**Name of Person to whom this applies**	**Diagnosis of illness or condition**	**Date of Diagnosis**	**Type(s) of treatment(s) or surgery(ies) including name of medication(s)**	**Date(s) of treatment(s)**	**Recovered**
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No
						☐ Yes ☐ No



ENDORSEMENT BY The Guardian Life Insurance Company of America

Group plan #: G- Certificate #: Effective Date: mo. day yr.

Initial Amount of Insurance ($): Life Supp. Life AD&D Dep. Life A&S LTD

Health Insurance: **Emp.** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No **Child** ☐ Yes ☐ No Dental Insurance: **Emp.** ☐ Yes ☐ No **Dep.** ☐ Yes ☐ No

This application is ☐ **Approved** ☐ **Rejected** Secretary: Date: By:

Risk Classification: Life Health Disability

I hereby apply for insurance to which I am entitled or may become entitled under any group insurance plan issued to ___________________________
____ by The Guardian Life Insurance Company of America (hereinafter called the Company). In addition, I hereby authorize my Employer to deduct from my earnings my required contributions, if any, toward premiums for this insurance. I hereby represent that the statements and answers to the questions are to the best of my knowledge and belief, full, complete and true. I understand that they shall form the basis upon which I may be included for insurance under the group plan.

IT IS MUTUALLY AGREED THAT: (1) The insurance applied for shall not become effective unless (a) the first premium has been paid to the Company, (b) the undersigned employee is unconditionally approved by the Company for such insurance as shown in the Endorsement, (c) the undersigned employee is actively at work for full pay on a full-time basis (at least 30 hours weekly) on the Effective Date specified in the Endorsement; otherwise he will become insured on the date he returns to work and satisfies these requirements (an employee will be deemed to have met the actively at work requirements on a regular Non-working day (excluding vacation days) if he was actively at work full-time for full pay on the last preceding regular work day). (2) No person, except the President, a Vice President or a Secretary of the Company, has authority to determine whether any contract(s) of insurance shall be issued on the basis of the application, to waive or modify any of the provisions of the application or any of the Company's requirements, to bind the Company by any statement or promise pertaining to any insurance contract(s) issued or to be issued on the basis of the application, or to accept any information or representation not contained in the written application; (3) The employer is hereby designated the Proposed Insured's representative for the purpose of receiving premiums and remitting them to the Company.

I have read both sides of this application including the Pre-Notices concerning the Medical Information Bureau and Fair Credit Reporting Act, copies of which have been received by me.

Signed at ____ Date ____________________

Witnessed by: __________________________________ Signature of applicant: ______________________________________

INSURANCE INFORMATION PRACTICES: Important: This authorization must be signed by applicant.

INVESTIGATIVE CONSUMER REPORT: I authorize The Guardian Life Insurance Company of America to obtain or have prepared an investigative consumer report as described in this notice.

MEDICAL RECORDS AND OTHER INFORMATION: I authorize any physician, medical practitioner, hospital, clinic, other health facility, consumer reporting agency, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and Non-medical information in its possession about me or my minor children to The Guardian Life Insurance Company of America or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me or my minor children.

I understand The Guardian Life Insurance Company of America will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. Guardian will not release any information obtained to any person or organization *except* to a reinsurance company, the Medical Information Bureau, or other persons or organization performing business or legal services in connection with my application, claim, or as may be lawfully permitted or required, or as I may further authorize.

I know that I may request and receive a copy of this authorization.

I agree that a photocopy of this authorization shall be as valid as the original.

I acknowledge receipt of Guardian's notice regarding its Insurance Information Practices, the Fair Credit Reporting Act, the Medical Information Bureau, and Medical Records.

I agree that this authorization shall be valid for two and one half years from the date shown below.

Signed at ____ Date ____________________

Signature of applicant: __________________________________ Signature of spouse: ___________________________________

IMPORTANT: **READ AND DETACH FOR YOUR RECORDS**

Thank you for choosing Guardian insurance. This notice is given to you at the time you apply for life or health insurance to tell you about the kinds of information we may obtain in connection with your application. We will treat all personal information about you as confidential. You have a right of access and correction with respect to this information. If you wish a more detailed explanation of our information practices, please send your written request to Corporate Secretary, The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY 10004-2616

Fair Credit Reporting Act Pre-Notice: When we begin to process your application, we may ask for a consumer report from a consumer reporting agency. All or part of that report may be an investigative consumer report. Such a report will include information about your character, general reputation, personal characteristics or mode of living. It will be obtained through personal interviews with people who know you. You may request to be interviewed in connection with this report. We may request later consumer reports, other than an investigative consumer report, at a future update, renewal or extension of the insurance for which you have applied.

At your request, we will tell you if we have asked for a consumer report or an investigative consumer report in the initial processing of your application. If we have, we will tell you the name and address of the consumer reporting agency to which we have made our request for a report. At your written request, we will give you more detailed information about the nature and scope of this kind of investigation.

Medical Information Bureau Pre-Notice: The Medical Information Bureau is a nonprofit membership organization of life insurance companies. The Bureau provides an information exchange for its members. On the request of any of its member companies to which you apply for life or health insurance, or to which you make a claim for benefits, the Bureau will supply the inquiring company with information in its files.

Guardian or our reinsurers may make a brief report of objective findings about you to the Bureau. We will not report what action we have taken on your application.

If you so request of the Bureau, it will arrange to disclose the information it may have in your file. But medical information will be disclosed only to your doctor. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek to correct the information according to procedures set forth in the Federal Fair Credit Reporting Act. The Bureau's address is Post Office Box 105, Essex Station, Boston, MA 02112, telephone 617-426-3660.

Medical Records: We may request information from health care providers or others who have records of your medical history, mental or physical condition, or treatment. Only qualified members of Guardian's staff will have access to your medical file to evaluate your eligibility for insurance or to service your claim for benefits under a policy. Your authorization will govern our request for information and any later disclosure of that information.