

All information contained in this questionnaire is strictly confidential.

EMPLOYER **MEMBER NUMBER:**¹

LAST NAME³ **FIRST NAME**³ **M.I.**

OCCUPATION **DATE EMPLOYED** DD / MM / YY F M **EMPLOYEE'S DATE OF BIRTH** D D M M Y Y Y

This Health Questionnaire is being completed for: Employee Only Employee & Dependents Dependents Only **TRN**²

| NAMES OF ELIGIBLE DEPENDENTS (SPOUSE/CHILDREN) | RELATIONSHIP TO EMPLOYEE | HEIGHT | WEIGHT | Date of Birth DD MM YY | TRN |
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PERSONAL HEALTH HISTORY

- For the Employee** (Note: If questionnaire is being completed for new dependents, give details only for dependents.)
- Are you employed by the employer named on this form for more than 30 hours every week? YES NO
 - 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.? YES NO
 - 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? YES NO
 - 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 disease. If 'No' state disease.) YES NO
 - Have you or any of your dependents been diagnosed with, or treated for HIV, AIDS, or ARC (AIDS related complications) (If 'Yes' underline disease). YES NO
 - 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? YES NO
 - Do you or any of your dependents have any disorder of the female organs or breast? YES NO
 - Are you or any of your dependents now pregnant? YES NO
 - Do you or any of your dependents have any physical impairments? YES NO
 - Do you or any of your dependents have any prior or existing history of alcoholism or drug abuse? YES NO
 - Have you or any of your dependents ever had an application for Life or Health Insurance declined, postponed, rated or modified in any way? YES NO

If the response to any of questions 2 - 11 is 'YES', give complete details below (continue on the reverse side or another sheet if necessary)

| Question No. | Full Name of Person Treated | Nature of Ailment | Date(s) of Visit(s) | Degree of Recovery: Full, Partial or Continuing | Name and Address of Attending Physician or Dentist |
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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.

Date _____ Signature of Employee _____

SECTION 2 TO BE COMPLETED BY THE EMPLOYER (When the questions relate to the employee)

- Is the employee now at work and able to perform all duties? YES NO *If NO give details* _____
- Has the employee been absent from work for more than 1 week due to sickness or injury during the past 6 months? YES NO _____
- Do you know of any prior or existing serious physical impairment, history of drug abuse or alcoholism? YES NO _____

Date _____ Signature of Employer _____ Title _____