Guardian Group
Guardian Life of The Caribbean Limited

GROUP HEALTH AND LIFE APPLICATION FORM

PLEASE COMPLETE IN BLOCK LETTERS **POLICY NO. LIFE** _____ **POLICY NO. HEALTH** _____

SECTION A – APPLICANT INFORMATION

NAME OF POLICYHOLDER: TECU CREDIT UNION	
NAME OF EMPLOYEE/INSURED:	**DATE OF BIRTH:** *(dd/mm/yyyy)*
EMAIL ADDRESS:	**GENDER:** ☐ **MALE** ☐ **FEMALE**
TELEPHONE (Home): **(Work):** **Ext:**	**(Cellular):**
MARITAL STATUS: ☐ **Single** ☐ **Married** ☐ **Common Law** ☐ **Divorced** ☐ **Widowed**	**OCCUPATION:**
IDENTIFICATION (tick one) ☐ **DP** ☐ **PP** ☐ **ID** *(Please attach a copy)* **Number**: _____ **TYPE OF COVERAGE:** ☐ **GROUP HEALTH** ☐ **GROUP LIFE**	**EXTRA COVERAGE:** *(if applicable)* ☐ **VOLUNTARY LIFE** ☐ **DEPENDENT LIFE**

SECTION B – CO-ORDINATION OF BENEFITS

1. Are you or your spouse covered by any other Medical or Health Plan? ☐ **Yes** ☐ **No**

If Yes, please give (a) NAME OF PLAN: **(b) NAME OF INSURANCE COMPANY:**

SECTION C – EMPLOYEE'S DEPENDENTS TO BE COVERED

RELATIONSHIP	NAME OF DEPENDENT/S	GENDER *(M/F)*	DATE OF BIRTH *(dd/mm/yyyy)*	EFFECTIVE DATE *(dd/mm/yyyy)*	COUNTRY OF RESIDENCE
SPOUSE					
CHILD					
CHILD					
CHILD					
CHILD					

A school letter is required every academic year for children attending full-time Tertiary school from age 22 to attainment of age 25.

SECTION D – BENEFICIARY INFORMATION (APPLICABLE TO GROUP LIFE ONLY)

RELATIONSHIP	NAME OF BENEFICIARY	GENDER *(M/F)*	DATE OF BIRTH *(dd/mm/yyyy)*	PERCENTAGE *(%)*

SECTION E – ACCOUNT INFORMATION FOR PAYMENT OF CLAIMS

ACCOUNT NUMBER: *(confirm with copy of bank statement)*	**NAME OF BANK:**
ACCOUNT TYPE: ☐ **SAVINGS** ☐ **CHEQUING**	**NAME OF BRANCH:**

I hereby apply for Registration as a Member of the Group Health Plan and/or Group Life Plan of the above Policyholder/Group and authorize deductions to be made by the Policyholder for contributions required to be paid by me in accordance with the terms and conditions of the Plan. I am familiar with the terms and conditions of the Plan and agree to be bound thereby. I also hereby declare that the above information is true and complete and shall form part of my application to Guardian Life of the Caribbean Limited.

EMPLOYEE SIGNATURE:	**DATE:** *(dd/mm/yyyy)*

SECTION F – FOR OFFICIAL USE ONLY (TO BE COMPLETED BY THE POLICYHOLDER)

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** ☐ **EMPLOYEE + FAMILY**		**IF GROUP LIFE, EMPLOYEE ANNUAL SALARY:** **TT$**_____
PLAN ADMINISTRATOR: NAME: _____ SIGNATURE: _____ DATE : *(dd/mm/yyyy)*_____		**PLACE COMPANY STAMP HERE:**

Requirements: One form of ID per person; Bank statement (for confirmation of Acct #)

Guardian Group
Guardian Life of The Caribbean Limited

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

PART A - GENERAL INFORMATION

POLICY HOLDER	
Address	Business Telephone No.
INSURED:	DATE EMPLOYED:
MARITAL STATUS ☐ Single ☐ Married	Home Telephone No.

PART B - PERSONS TO BE COVERED

Provide first name of insured and all family members to be covered plus last name of any member if different from the insured's

LAST NAME FIRST NAME	SEX	BIRTH DATE			AGE	HEIGHT	WEIGHT
Insured							
Spouse							
Dependant							
Dependant							
Dependant							
Dependant							
Dependant							
Dependant							

NAME OF PERSONAL PHYSICIANS	ADDRESS	DATE LAST CONSULTED			REASON AND TREATMENT GIVEN

PART C - MEDICAL QUESTIONNAIRE FOR APPLICANT AND DEPENDANTS

SECTION A - CHECK EACH ITEM YES OR NO. (INSERT ONE TICK PER CHILD)

Have you or any person in this application ever been treated for or ever had any known indication of:

Yes	No	Yes	No	Yes	No	Yes	No
EMP		SPOUSE		CHILD		CHILD	

(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, hernia, 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 Deficiency 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?

(l) Allergies, anaemia, or other disorder of the blood?

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

PART C (cont'd)

SECTION B - in addition to the conditions listed in SECTION A, to the best of your knowledge and belief has any person named in this application:

	Yes	No	Yes	No	Yes	No	Yes	No
	EMP		SPOUSE		CHILD		CHILD	
(a) Had a check-up, consultation, illness, injury or surgery?								
(b) Had any mental or physical disorder not listed above?								
(c) Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?								

1. **SECTION C** - If you have checked "YES" to any part of SECTION A or SECTION B, please provide complete information regarding diagnosis, symptom(s) or treatment (including all hospitalization, surgery, and diagnostic testing, results) and dates. If more space is needed, attach a separate sheet of paper.

Patient's Full Name	Diagnosis/Symptom	Duration Dates		Details	Recovery *Check only one box.*	
		From	To			
					Full	Partial
					Full	Partial
					Full	Partial
					Full	Partial
					Full	Partial
					Full	Partial

2. Are you or any dependant listed as using or expected to be using medication or serum in the next three months?

INSURED YES ☐ NO ☐ SPOUSE/CHILDREN YES ☐ NO ☐

If you or any dependant listed are currently using medication or serum complete section below.

Name of Person	Name of Drug/Medication or Serum	Monthly cost of Drug/Medication or Serum	Strength of Drug or Medication	Daily Dosage of Drug/Medication or Serum	Length of time on Drug/Medication or Serum

DECLARATION

All applicants must complete

NOTE THE INFORMATION ON THIS FORM IS TO BE CONSIDERED CONFIDENTIAL.

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

I/We hereby authorize any licensed physician, medical practitioner, hospital, clinic, medical facility or organization which has records of my/our health records of my/our health to release such information to Guardian Life of the Caribbean Limited. A photocopy of this signed authorization shall be as valid as the original.

I/We understand and agree that any injury that occured on or 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/We understand and agree that coverage shall not become effective until approved by Guardian Life of the Caribbean Limited.

Signature of Insured ..... Siganture of Spouse .....

Dated ...../...../..... Dated ...../...../.....
Day Month Year Day Month Year

Date: _____
Day/Month/Year

The Insurance Department
TECU Credit Union
Health Plan

Member's Name: _____

Member's Number: _____

I hereby authorize **TECU CREDIT UNION** to deduct the health plan premium monthly from my member share account (151).

Select the coverage option of your choice by checking the box:

DIVISIONS	MAJOR MEDICAL COVERAGE	ACTIVES Members ages 64 and Under		
		Member Only	Member + One Dependent	Member + Family
Division 1	$250,000	☐	☐	☐
Division 2	$400,000	☐	☐	☐
Division 3	$750,000	☐	☐	☐
DIVISIONS	**MAJOR MEDICAL COVERAGE**	**RETIREES Members ages 65 and Over**		
		Member Only	Member + One Dependent	Member + Family
Division 4	$250,000	☐	☐	☐
Division 5	$400,000	☐	☐	☐

Member's Signature: _____

MHP01202201

FOR INTERNAL USE ONLY			
Processed by:		HP Screen Created:	Date: _____ Day/Month/Year
Data Processed by:	Name: _____	Signature: _____	Date: _____ Day/Month/Year
Authorized by:	Name: _____	Signature: _____	Date: _____ Day/Month/Year

Guardian Group
Guardian Life of The Caribbean Limited

GUARDIAN LIFE OF THE CARIBBEAN LIMITED
GROUP HEALTH PLAN
MEDICAL EXAMINER'S REPORT

1. Proposed Applicant (please print)	2. Date of Birth			3. Height – in shoes	4. Weight – clothed
	Day	Month	Year	.....cms	.....kg

5. Marital Status	6. Any weight change in the past year? Reason
[ ] Married [ ] Single [ ] Widowed [ ] Divorced	[ ] Yes [ ] No [ ] Gain [ ] Loss cms.....

7. A. Name and address of your personal physician?..... (If none, so state)
   B. Date and reason last consulted?.....
   C. What treatment was given or medication prescribed?.....

	Yes	No
8. Have you ever been treated for or ever had 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, hernia, appendicitis, colitis, diverticulitis, hemorrhoids, recurrent indigestion or other disorder of the stomach, intestines, liver or gallbladder?	[ ]	[ ]
F. Sugar, albumin, blood or pus in urine, venereal disease, stone or other disorder of 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 Deficiency 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?	[ ]	[ ]
L. Allergies, anaemia, or other disorder of the blood?	[ ]	[ ]
9. A. Do you use alcohol?	[ ]	[ ]
B. How much daily?.....		
10. A. Do you smoke?	[ ]	[ ]
B. How many cigarettes daily?.....		
11. Ever used or dealt in barbiturates, narcotics or other drugs, excitants or hallucinogens, except as medication prescribed by a physician?	[ ]	[ ]
12. Are you under observation or taking treatment?	[ ]	[ ]
13. Other than the above, have you within the past 5 years:		
A. Been advised to have any diagnostic test, hospitalization or surgery which was not completed?	[ ]	[ ]
B. Had any mental or physical disorder not listed above?	[ ]	[ ]
C. Had a check-up, consultation, illness, injury or surgery?	[ ]	[ ]
D. Been a patient in a hospital, clinic, sanatorium, or other medical facility?	[ ]	[ ]
E. Had an electrocardiogram, x-ray or other diagnostic test?	[ ]	[ ]
14. Have you ever had military or police deferment, rejection or discharge because of a physical or mental condition?	[ ]	[ ]
15. Have you ever requested or received a pension, benefits or payment because of an injury, sickness or disability?	[ ]	[ ]
16. Females Only		
A. Are you now pregnant? How far advanced?.....months	[ ]	[ ]
B. How many children?.....pregnancies?.....		
C. Age of youngest child.....		
D. Have you ever had or been told you had:	[ ]	[ ]
1. Any menstrual disorder?	[ ]	[ ]
2. Any disease of the breast, pelvis?	[ ]	[ ]
3. Any abortions, miscarriages?	[ ]	[ ]
17. Males Only: Are you involved or have you ever been involved in any homosexual activities?	[ ]	[ ]

Details of yes answers:
Identify Question number, circle applicable items, include diagnoses, dates, duration and names and addresses or all attending physicians and medical facilities.

18. Family History: Tuberculosis, Diabetes, Cancer, High Blood Pressure, Heart or Kidney Disease, Mental Illness or Suicide? Yes No

	If Alive Age	State of Health	If Deceased Age at Death	Cause
Father	.....	.....	.....	.....
Mother	.....	.....	.....	.....
Brothers	.....	.....	.....	.....
Sisters	.....	.....	.....	.....

No. Living.....
No. Dead.....

I have read the above statements and they are complete and true to the best of my knowledge and belief and are in continuation of and form part of my application for insurance to..... Dated.....

.....
Medical Examiner

.....
Proposed Applicant

AUTHORIZATION FORM
THIS FORM MUST BE COMPLETED IN EVERY CASE
I HEREBY AUTHORIZE any physician or practitioner who has observed me for diagnosis or treatment, or for any disease or ailment, any hospital or clinic where I have been a patient for diagnosis, treatment, disease or ailment, or any insurance company to which I have applied, to give full particulars, including any prior medical history, to GUARDIAN LIFE OF THE CARIBBEAN LIMITED to which I am making application for insurance. A photocopy of this authorization shall be as valid as the original.

Date..... Proposed Applicant.....

MEDICAL EXAMINER'S REPORT

1. Name of Applicant

2. Name of Policyholder

3. A. How long have you known the proposed insured?
   B. Is general appearance healthy?

4 (a) Height in shoes……centimeters MEASURED……..
(b) Weight in ordinary clothes……kilograms WEIGHED……..

5. BODY MEASUREMENTS
CHEST – EXPIRATION……..cms INSPIRATION…….cms
ABDOMEN……cms

6. BLOOD PRESSURE – Sitting position
(a) SYSTOLIC DIASTOLIC (b) HAS THE PROPOSED

Cessation of Sound [ ] [ ] INSURED EVER BEEN TREATED BY DRUGS FOR HYPERTENSION?

AFTER CAREFUL INQUIRY AND EXAMINATION DO YOU FIND PAST OR PRESENT EVIDENCE OF ABNORMALITY OF:

7. CARDIOVASCULAR SYSTEM? YES [ ] NO [ ]
(a) HEART SOUNDS – quality, murmurs, etc.

HEART CHART – Complete Heart Chart only if any abnormality of Cardiovascular system including B.P. exceeding 150 systolic or 90 Diastolic

A. IS THERE A MURMUR? ……

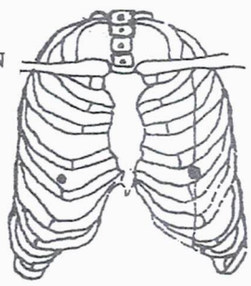
B. HOW DOES EXERCISE AFFECT MURMUR?……
……

C. HOW DOES CHANGE IN POSITION AFFECT MURMUR?……
……

D. IS MURMUR TRANSMITTED?……..WHERE?……

TIMING		INTENSITY		QUALITY	
SYSTOLIC	[ ]	FAINT	[ ]	SOFT	[ ]
PRESYSTOLIC	[ ]	MODERATE	[ ]	BLOWING	[ ]
DIASTOLIC	[ ]	LOUD	[ ]	ROUGH	[ ]

E. IS THERE A THRILL?……
F. IS HEART ENLARGED?……
G. IS THERE ABNORMAL ACCENTUATION OF THE HEART SOUNDS?……
H. IS THERE EVIDENCE OF DECOMPENSATION?……



Indicate on chart position of apex, maximum point of intensity of murmur, area over which heard and the direction of transmission.

(Use Stethoscope on bared chest, before and after exercise in sitting, recumbent and left lateral positions)
(b) HEART SIZE YES [ ] NO [ ]

(c) PULSE – Rhythm – Characte

After 10 Toe YES [ ] NO [ ]

	At rest	Touches	2 min. later
Rate			

(d) CIRCULATION –Shortness of Breath, edema, suggestive pain, etc YES [ ] NO [ ]

8. LUNGS? Chest Deformity, emphysema rales, etc. YES [ ] NO [ ]

9. ABDOMEN? Visceral organs, external genitalia, size of liver and spleen, evidence of surgery YES [ ] NO [ ]

10. HEAD AND NECK? – Vision, hearing , speech Thyroid, etc YES [ ] NO [ ]

11. SKIN, LYMPH NODES, BREASTS, MUSCLES, BONES OR JOINTS? YES [ ] NO [ ]

12. NERVOUS SYSTEM? – Reflexes, weakness or tremors, mental state YES [ ] NO [ ]

PLEASE COMMENT FULLY IN THIS SPACE ON ANY ABNORMAL FINDINGS OBTAINED THROUGH INQUIRY OR EXAMINATION - INCLUDE RECOMMENDATIONS FOR ADDITIONAL TESTS OR INVESTIGATION.

13. HAVE YOU REASON TO BELIEVE THAT THERE IS ANYTHING UNFAVOURABLE ABOUT HABITS IN REGARD TO ALCOHOL OR DRUGS?

14. DO YOU KNOW OF ANY SIGNIFICANT MEDICAL HISTORY OR INFORMATION NOT ALREADY MENTIONED ON EITHER SIDE OF THIS FORM YES [ ] NO [ ]
Comment here or by confidential letter to Medical Consultant, Guardian Life of the Caribbean Limited.

15. URINALYSIS – Results of Examiner's urinalysis – SUGAR PRESENT?……PROTEIN PRESENT?……SPECIFIC GRAVITY……
A microscopic urinalysis is required if:
(i) Abnormality of urine noted by examiner of if there is a history of abnormality. (ii) Blood Pressure is elevated.

I have carefully examined……this day of ……..at o'clock AM [ ] PM[ ]
Examination was made in private at [ ] my office [ ] residence of Proposed Applicant [ ] place of business of Proposed Applicant

……
Medical Examiner's Signature

……
Examiner's Address

……
Medical Examiner's Name in Block Letters