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:	
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 bank acct #)

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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: _____

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