The group division of Family Guardian Insurance Company Limited

GROUP EVIDENCE OF INSURABILITY

1. Employee Name: ______________________	2. Date of Birth: (mm/dd/yyyy) __________
3. Employee Gender: Male Female	4a. Employee Height: ____ft. ____in. / 4b. Employee Weight: ______lbs.
5. Employer: ______________	6. Employee Phone Number: Work: __________ Home: __________ / 7. Employee National Insurance Number ______________

IF DEPENDENT COVERAGE IS BEING APPLIED FOR, PLEASE COMPLETE THE FOLLOWING FOR EACH DEPENDENT:

8. Dependent's Name	Sex (M/F)	Date of Birth (mm/dd/yyyy)	Height	Weight
a.	Male Female		____ft. ____in.	______lbs.
b.	Male Female		____ft. ____in.	______lbs.
c.	Male Female		____ft. ____in.	______lbs.
d.	Male Female		____ft. ____in.	______lbs.
e.	Male Female		____ft. ____in.	______lbs.

9. Has the employee or any of the above Dependents, within the past five (5) years:

a. **Consulted any doctors, therapists, counselors or healthcare providers of any kind or received any treatment?** **YES NO**

b. **Had any loss of weight, been in a hospital, sanitarium or other institution for observation or treatment? Had Electro-cardiograms, X-Rays, blood studies or other diagnostic tests?** **YES NO**

10. Has the Employee or any of the above Dependents ever had or been treated for any of the following?

	YES	NO		YES	NO
a. Heart disease/Stroke?			h. Emotional problems or counseling?		
b. Back/bone/joint problems?			i. Epilepsy/seizures?		
c. Cancer?			j. Disease of eye or ear?		
d. Diabetes?			k. High blood pressure		
e. Asthma or Bronchitis?			l. Medical diagnosis of AIDS or an AIDS – related condition		
f. Dizziness or fainting spells?			m. Alcoholism or drug abuse?		
g. Varicose veins or circulation problems?			n. Any condition other than those above?		

	YES	NO
11. Is the Employee or any of the above Dependents taking prescribed medication or under medical treatment?		
12. Is the Employee or any of the Dependents pregnant?		
13. Has surgery or treatment for the Employee or any of the above Dependents been advised but not performed?		

14. If the answers to any of the above questions is "YES" for the Employee or any of the above Dependents, please provide item number and answer the following questions (use additional pages if necessary).

Name of Person	Item Number	Date of Treatment (mm/dd/yyyy)	Physician consulted or place of treatment	Symptom, illness or diagnosis	Treatment received and/or present condition

It is understood and agreed that (a) the above statements and answers are true and complete to the best of my knowledge and (b) that they are the basis on which benefits requested by me may be provided. Furthermore, it is understood that additional information or examination by a physician may be required.

I authorize any physician, medical practitioner, hospital, clinic, other medically-related facility, consumer reporting agency, insurance or reinsuring company, or employer having certain information about my spouse, children or me to release to the Company or its legal representative, any and all such information. The nature of the information authorized to be disclosed includes information about physical conditions, health histories, avocations, ages, occupations and personal characteristics. This authorization includes information about drugs, alcoholism or mental illness.

I understand the information obtained by use of the Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits. I also authorize the Company to release any information obtained to reinsuring companies or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may further authorize.

I agree that a photographic copy of this Authorization shall be as valid as the original.

______________________________ ______________________________

Employee's signature **Date**