GROUP CHANGE REQUEST AND BENEFICIARY UPDATE FORM EB 186

Tei (876)978-4473 Fzu (876)927-473 828-MEDECUSWebsite: www.medecus.com	
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Guardian Group	EB 186
Aember / Employee Name³ Aember No.¹ Aember No.¹ RN²(Member)	Group No. Employer
ENDENTS (UST DETAILS	SECOND HEALTH ONLY
SURNAME	MI SEX RECAILONSHIP
TERMINATION OF MEMBER / DEPEN SURNAME	/ DEPENDENTS (UST DETAILS BELLY COLOR HEALTH& LIFE FIRST NAME MI SEX RELATIONSHIP DATE OF BIRTH REASON
Tourist and the supplier of th	
CHANGE OF INFORMATION	NAME OFTHE EMPLOYEE DEPENDENT BIRTH/GENDER OF THE EMPLOYEE DEPENDENT
IROM CURRENT/PREVIOUS NAME	DATE OF BIRTH
O FIRST NAME	
INDICATE REASON FOR CHANGE/CORRECT MARRIAGE OTHER (Specify)	CORRECTION (Submit supporting documents)
APPOINTMENT/CHANGE OF BENEFICIARY	CIARY GROUP LIFE & PENSION
(name of member)	
thome address of Insured) residing at	ed by Guardian Life Limited
for do hereby revoke any previous designation hereby designate and appoint: (State full no	do hereby revoke any previous designation or appointment of beneficiary(ies) with respect to the said Group Life/Pension Plan and subject to the condition set forth below, do hereby designate and appoint: (State full name of beneficiary(ies) and relationship to person whose life is insured; If more than one beneficiary, state here proportion for each).
NOIE: You may name a trustee for any be the trustee has been named.	enefrciary. However, <u>if beneficiary is under age 18 years old, a trustee must be named.</u> Please state clearly the beneficiary for whom
BENEFICIARY NAME	RELATIONSHIP LIFE(x) PENSION(x) DATE OF BIRTH TRUSTEE NAME (if applicable)
as benenidal yltes) to receive an suns payal I AGREE TO ANY CHANGE IN CONTRIBUT	as beneficially(les) to receive an sums payable under the terms of the said scheme/Plan by reason of my death. I AGREE TO ANY CHANGE IN CONTRIBUTION NECESSITATED BY THE REQUESTED CHANGE(S) IN COVERAGE.
Signed at	this day of 20
WITNESS	SIGNATURE OF EMPLOYEE DATE
NAME OF AUTHORIZED OFFICER OF EMPLOYER	PLOYER SIGNATURE OF AUTHORIZED OFFICER OF EMPLOYER POSITION OF AUTHORIZED OFFICER OF EMPLOYER
	DATE
	For Official Use; Index I by #:
	² TRN: ³ Name of Member:

HEALTH HISTORY QUESTIONNAIRE

DATE		
POSITION OF AUTHORIZED OFFICER OF EMPLOYER	RE OF AUTHORIZED OFFICER OF EMPLOYER	NAME OF AUTHORIZED OFFICER OF EMPLOYER SIGNATURE
YES NO If YES give details past 6 months?	rm his/her duties? n 1 week due to sickness or injury during the p pairment, history of drug abuse or alcoholism?	 Is the employee absent from work and unable to perform his/her duties? Has the employee been absent from work for more than 1 week due to sickness or injury during the past 6 months? Do you know of any prior or existing serious physical impairment, history of drug abuse or alcoholism?
relate to the employee)	EMPLOYER (When the questions re	TO BE COMPLETED BY THE I
m the basis upon which any insurance will be made Life Limited information about my health, habits or dian Life Limited reserves the right to request an	and complete, and I understand that they form cally related facility to disclose to Guardian Lid above. It is further understood that Guardin.	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. Signature of Employee
	(FULL, PARTIAL OR CONTINUING)	
UE ON ANOTHER SHEET, IF NECESSARY) NAME AND ADDRESS OF ATTENDING PHYSICIAN OR DENTIST	GIVE COMPLETE DETAILS BELOW (CONTINUE OF ALLMENT DEGREE OF RECOVERY:	IF THE RESPONSE TO ANY OF QUESTIONS 2-11 IS 'YES', QUESTION FULL NAME OF PERSON TREATED NATUR
ostponed, rated	ation for Life or Health Insurance declined, po	11. Have you or any of your dependents ever had an application for Life or Health Insurance declined, postponed, rated or modified in any way?
	sting history of alcoholism or drug abuse?	•
	pairments?	8. Are you or any of your dependents now pregnant?9. Do you or any of your dependents have any physical impairments?
	the female organs or breast?	7. Do you or any of your dependents have any disorder of the female organs or breast?
al attention or surgical	mplating, or been advised to seek any medical	6. 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?
ARC (AIDS related complications)? (If Yes;	th, or treated for HIV, AIDS, or ARC (AIDS relate	5. Have you or any of your dependents been diagnosed with, or treated for HIV, AIDS, or underline disease.)
od Disease, High Blood Pressure, Disorder, or any other disease	r been told that you have Heart Trouble, Blooc , Ulcer, Asthma, Epilepsy, Alcoholism, Mental I	4. Have you or any of your dependents been treated for, or been told that you have Heart Trouble, Blood Disease, High Blood I Kidney Disorder, Diabetes, Tuberculosis, Cancer, Tumor, Ulcer, Asthma, Epilepsy, Alcoholism, Mental Disorder, or any other not listed anywhere on this application? (If 'Yes' underline/state disease.)
treated in any hospital or other	ents undergone a surgical operation, or been t	3. During the last 5 years, have you or any of your dependents undergone a surgical operation, or been treated in any hospital institution?
a Doctor, or been advised to have	ND 'YES' OR 'NO' TO THE FOLLOWING QUEST ents consulted, been examined or treated by a MRI) etc.?	FOR THE EMPLOYEE AND/OR DEPENDENTS KINDLY RESPOND 'YES' OR 'NO' TO THE FOLLOWING QUESTIONS. 2. During the last 5 years, have you or any of your dependents consulted, been examined or treated by a Doctor, or been advised any diagnostic tests (e.g. blood tests, X-Rays, CAT Scan, MRI) etc.?
	n for more than 30 hours every week?	 Are you employed by the employer named on this form for more than 30 hours every week?
GIVE DETAILS ONLY FOR DEPENDENTS.) YES NO	(NOTE: IF QUESTIONNAIRE IS BEING COMPLETED FOR NEW DEPENDENTS, GIV YEE	(NOTE: IF QUESTIONNAIRE IS BEING
	PERSONAL HEALTH HISTORY	ACCOUNTS A LA ALBERTA AND PROPOSOTORY PRICE. A LA ALBERTA BERT AND PRICE BERT BERT AND PRICE BERT BERT BERT BERT BERT BERT BERT BER
4 SEX TRN	IIP HEIGHT WEIGHT DATE OF BIRTH	NAME RELATIONSHIP
PENDENTS DEPENDENTS ONLY	T: EMPLOYEE ONLY EMPLOYEE & DEPENDENTS	This Health History Questionnaire is being completed for:
	ation contained in this questionnaire is strictly confidential.	All informat