

**The Guardian Life Insurance Company of America  
The Guardian Insurance & Annuity Company, Inc.**

Midwest Regional Office  
PO Box 8012  
Appleton WI 54912-8012

Northeast Regional Office  
PO Box 26040  
Lehigh Valley PA 18002-6040

Bridgewater Office  
PO Box 425  
E. Bridgewater, MA 02333-0425

Western Regional Office  
PO Box 2454  
Spokane WA 99210-2454

**EVIDENCE OF INSURABILITY FOR  
NON-MEDICAL COVERAGES**

Please complete in ink. Erasures and changes invalidate this form.

Planholder Name (Company Name)	Group Plan No.
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**Complete the following information for each person to be underwritten:**

Name (Last, First, Middle Initial)	Sex	Birthdate	Height	Weight	Full Time Student?
Employee:	<input type="checkbox"/> M <input type="checkbox"/> F				
Spouse:	<input type="checkbox"/> M <input type="checkbox"/> F				
Child:	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
Child:	<input type="checkbox"/> M <input type="checkbox"/> F				<input type="checkbox"/> Yes <input type="checkbox"/> No
Employee's Social Security Number		Date of Marriage		Employee's Place of Birth (State)	

**IF APPLYING FOR LIFE INSURANCE: questions 1-4 must be answered for each person to be underwritten  
IF APPLYING FOR DISABILITY INSURANCE: all five questions must be answered in reference to the employee only**

1. In the past 10 years been treated for or diagnosed as having: heart; liver or kidney disorder; neurological disorder; diabetes; stroke; cancer; tumor; mental or nervous disorder; AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex (ARC); or been advised to have treatment for drug abuse (including prescription drugs); or alcoholism?	<b>Employee</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Spouse</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Child</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past 5 years used illegal drugs?	<b>Employee</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Spouse</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Child</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past year had: fever persisting more than one month; significant involuntary weight loss; diarrhea persisting more than one month; oral candidiasis (thrush); lymphadenopathy (enlarged or swollen glands)?	<b>Employee</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Spouse</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Child</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
4. Excluding HIV testing and AIDS/ARC, in the past year: (a) consulted or been examined by or treated by a physician, practitioner or specialist? (Include routine physicals only when there is an existing or newly diagnosed medical condition); (b) been in a hospital or other facility for observation, diagnosis, treatment or an operation?; (c) been prescribed medication(s) - (other than for colds, flu or allergies)?	<b>Employee</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Spouse</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Child</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
5. <b>If applying for disability coverage, please complete these additional questions:</b> (a) In the past 5 years, been treated for conditions of the back, neck, spine, or arthritis?; (b) Are you currently pregnant?; (c) Excluding your employer sponsored group disability plan, are you currently insured for any other disability coverage? If "Yes", what is the total amount of coverage already in-force? \$ _____	<b>Employee</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

**Be certain to read, sign and date this application on the reverse side.**

**For each "Yes" answer to questions 1 through 5b give details below. (\*Continue on reverse side if additional space is needed.)**

Ques. No.	Name of Patient	Practitioner's Name & Address	Hospital Name & Address	Condition	Duration of symptoms, treatment & degree of recovery	Dates mo/yr

**ENDORSEMENT (GUARDIAN USE ONLY)**

<b>Employee:</b> <input type="checkbox"/> Approved <input type="checkbox"/> Declined    Premium Class: <input type="checkbox"/> Preferred <input type="checkbox"/> Standard Optional Life: \$ _____    Guardian's Universal Life: \$ _____	<b>Child:</b> <input type="checkbox"/> Approved <input type="checkbox"/> Declined Optional Life: \$ _____    Child Term Rider: \$ _____		
<b>Spouse:</b> <input type="checkbox"/> Approved <input type="checkbox"/> Declined    Premium Class: <input type="checkbox"/> Preferred <input type="checkbox"/> Standard Optional Life: \$ _____    Spouse Term Rider: \$ _____	Excess Life \$ _____ <input type="checkbox"/> Approved <input type="checkbox"/> Declined Long Term Disability \$ _____ <input type="checkbox"/> Approved <input type="checkbox"/> Declined Short Term Disability \$ _____ <input type="checkbox"/> Approved <input type="checkbox"/> Declined		
Effective Date:	By: _____	Date: _____	Secretary

\* Additional space if questions 1 through 5b were answered "Yes".

Ques. No.	Name of Patient	Practitioner's Name & Address	Hospital Name & Address	Condition	Duration of symptoms, treatment & degree of recovery	Dates mo/yr

I hereby represent that the statements and answers to the questions on this application are to the best of my knowledge and belief, full, complete and true. I understand that they will form the basis of any coverage under the Group Plan for which Evidence of Insurability is required.

Also, it is mutually understood and agreed that (1) the Company reserves the right to request, at its expense (in the case of a late entrant, it is not at the Company's expense), that I be examined by an accredited medical examiner selected by the Company; (2) no Group Insurance will be binding or in force until satisfactory evidence of insurability is submitted and approved by the Insurance Company at the Home Office as shown in the Endorsement; and (a) I am actively at work on a full-time basis (as defined in the Group Plan) for full pay on the date my Group Insurance becomes effective; otherwise, (b) I will become insured on the date I do return to work and satisfy a waiting period (as defined in the Group Plan) of full-time service; (3) coverage for my dependents will not take effect if a dependent other than a newborn is: (a) confined to the hospital or other health care facility; or (b) is unable to perform the normal activities of someone of like age and sex; (4) no person, except the President, a Vice President or a Secretary of the Company, has authority to: (a) determine whether any contract(s) of insurance shall be issued on the basis of the application; (b) waive or modify any of the provisions of the application or any of the Company's requirements; (c) bind the Company by any statement or promise pertaining to any insurance contract(s) issued or to be issued on the basis of the application; or (d) accept any information or representation not contained in the written application; (5) the employer is hereby named the Proposed Insured's representative for the purpose of receiving premiums and remitting them to the Company.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation (does not apply to life insurance).

**Investigative Consumer Report**

I authorize The Guardian Life Insurance Company of America or The Guardian Insurance and Annuity Company to obtain or have prepared an investigative report as described in the Insurance Information Practices Notice.

**Medical Records and Other Information**

I **authorize** any physician, medical practitioner, hospital, clinic, other health facility, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me or my eligible dependents to The Guardian Life Insurance Company of America or The Guardian Insurance and Annuity Company or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me or my eligible dependents.

I **understand** The Guardian Life Insurance Company of America or The Guardian Insurance and Annuity Company will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. Guardian will not release any information obtained to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim or as may be lawfully permitted or required, or as I may further authorize.

I **know** that I may request and receive a copy of this authorization.

I **agree** that a photocopy of this authorization will be as valid as the original.

I **acknowledge** receipt of and have read Guardian's Insurance Information Practices Notice regarding its Insurance Information Practices, the Fair Credit Reporting act, the Medical Information Bureau and Medical Records.

I **agree** that this authorization will be valid for two and one half years from the date shown below.

<b>Signature of Employee x</b>	<b>Date</b>
<b>Signature of Spouse x</b>	<b>Date</b>
<b>Signature of Child x (if over 18)</b>	<b>Date</b>

**INSURANCE INFORMATION PRACTICES NOTICE**  
**Read and Detach for your records**

Thank you for choosing Guardian insurance. This Insurance Information Practices Notice is given to you at the time you apply for life or health insurance to tell you about the kinds of information we may obtain in connection with your application. We will treat all personal information about you as confidential. You have a right of access and correction with respect to this information.

**Fair Credit Reporting Act Pre-Notice:** When we begin to process your application, we may ask for a consumer report from a consumer reporting agency. All or part of that report may be an investigative consumer report. Such a report will include information about your character, general reputation, personal characteristics or mode of living except as may be related directly or indirectly to your sexual orientation. It will be obtained through personal interviews with people who know you. You may request to be interviewed in connection with this report. We may request later consumer reports, other than an investigative consumer report, at a future update, renewal or extension of the insurance for which you have applied.

At your request, we will tell you if we have asked for a consumer report or an investigative consumer report in the initial processing of your application. If we have, we will tell you the name and address of the consumer reporting agency to which we have made our request for a report. You may inspect and receive a copy of such report by contacting the consumer reporting agency directly. At your written request, we will give you more detailed information about the nature and scope of this kind of investigation.

**Medical Information Bureau Pre-notice:** The Medical Information Bureau is a nonprofit membership organization of life insurance companies. The Bureau provides an information exchange for its members. On the request of any of its member companies to which you apply for life or health insurance, or to which you make a claim for benefits, the Bureau will supply the inquiring company with the information in its files. Guardian or our reinsurers may make a brief report of objective findings about you to the Bureau. We will not report what action we have taken on your application.

If you so request of the Bureau, it will arrange to disclose the information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek to correct the information according to procedures set forth in the Federal Fair Credit Reporting Act. The Bureau's address is Post Office Box 105, Essex Station, Boston, MA 02112, telephone 617-426-3660.

**Medical Records:** We may request information from health care providers or others who have records of your medical history, mental or physical condition, or treatment. Only qualified members of Guardian's staff will have access to your medical file to evaluate your eligibility for insurance or to service your claim for benefits under a policy. Your authorization will govern our request for information and any later disclosure of that information.

I hereby represent that the statements and answers to the questions on the attached form are, to the best of my knowledge and belief, full, complete and true. I understand that they shall form the basis upon which I may be included for insurance.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation (does not apply to life insurance).

**I authorize** any physician, medical practitioner, hospital, clinic, other health facility, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me or my eligible dependents to The Guardian Life Insurance Company of America or The Guardian Insurance and Annuity Company or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me or my eligible dependents.

**I understand** The Guardian Life Insurance Company of America or The Guardian Insurance and Annuity Company will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. Guardian will not release any information obtained to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim or as may be lawfully permitted or required, or as I may further authorize.

**I know** that I may request and receive a copy of this authorization.

**I agree** that a photocopy of this authorization shall be as valid as the original.

**I acknowledge** receipt of and have read Guardian's notice regarding its Insurance Information Practices Notice.

**I agree** that this authorization shall be valid for two and one half years from the date signed.