## 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 ☐ Western Regional Office PO Box 2454 Spokane WA 99210-2454

## EVIDENCE OF INSURABILITY FOR NON-MEDICAL COVERAGES

Complete the following information for each person to be underwritten:    Name (Last, First, Middle Initial)   Sex   Sirrhdate   Height   Weight   Full Time   Student?	Please complete in ink. Erasu	res and changes invalid	ate this form.					
Name (Last, First, Middle Initial)   Sax   Birthdate   Height   Weight   Full Time   Employee:	Planholder Name (Company Name)					Group Plan No.		
Name (Last, First, Middle Initial)   Sax   Birthdate   Height   Weight   Full Time   Employee:	Complete the following info	rmation for each perso	n to be underwrit	ten:				
Child:	Name (Las	st, First, Middle Initial)			Birthda	te He	ight Weight	Full Time
Child:	Employee:			□ M □ F				Student?
Child:	Spouse:			□M□F				
Employee's Social Security Number   Home Pinone Number   Cell Pinone Number   Date of Marriago   Employee's Place of Birth (State)	Child:			□M□F				☐ Yes ☐ No
Employee's Place of Birth (State)  Amount in Force  Amount in Force  Amount in Force  Amount in Force  Amount seng Requested  Amount seng Requested  FAPPLYING FOR LIFE INSURANCE: questions 1-4 must be answered for each person to be underwritten  FAPPLYING 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, or been advised to have treatment for drug abuse (including prescription drugs); or alcoholism?  2. In the past 5 years used illegal drugs?  3. (a) Ever tested positive for HIV (Human Immunodeficiency Virus) antibodies? (b) In the past year had: fever persisting more than one month; significant involuntary weight loss; diarrhea persisting more than one month; oral candidiasis (funsh); hymphadenopathy (enlarged or swollen glands)?  4. 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 medicalion(s) - (other than or other facility for observation), diagnosis, treatment or an operation?; (c) been prescribed medicalion of symptoms; (c) Excluding your employer sponsored group disability plan, are you currently insured for any other disability  [Employee] Yes   No Child   Yes   No Spouse   Yes   No Child	Child:			□M□F				☐ Yes ☐ No
Frail Address	Home Address							
Amount Brang Requested   Amount Being Requested   Amount Being Requested   FAPPLYING FOR LIFE INSURANCE: questions 1-4 must be answered for each person to be underwritten   FAPPLYING FOR DISABILITY INSURANCE: all five questions must be answered in reference to the employee only   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; or been advised to have treatment for drug abuse (niciding prescription drugs); or alcoholism?   Employee   Yes   No Child	Employee's Social Security Number	Home Phone Number	Cell Phor	ne Number	Da	te of Marriage	Employee's Pl	ace of Birth (State)
FAPPLYING FOR LIFE INSURANCE: questions 1-4 must be answered for each person to be underwritten   FAPPLYING FOR DISABILITY INSURANCE: all five questions must be answered in reference to the employee only	Email Address			How Best to C	ontact			
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Spouse   Yes   No Child   Yes   No Other facility for observation, diagnosis, treatment or an operation?; (c) been prescribed medication(s) - (other than for colds, flu or altergies)?  5. If applying for disability coverage, please complete these additional questions: (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? \$  For each "Yes" answer to questions 1 through 5b give details below. ("Continue on reverse side if additional space is needed.)  Ques. Name of Practitioner's Name & Hospital Name & Condition Patient & degree of No. Patient Address Address Patient facility, the MIB, Inc., 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 its legal representatives. Medical information means all information means all information in the possession of the possession of the reverse side of this application.  Signature of Employee x	2 (a) Ever tested positive fo	r HIV /Human Immunod	eficiency Virus) ant	tihodies? (h) I	In the past ve	ar had: fever		
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Coverage? If "Yes", what is the total amount of coverage already in-force? \$	(b) Are you currently preg	nant?; ver sponsored group dis	ability plan, are you	currently ins	ured for any	other disability	Linbioyee	
Ques. Name of Practitioner's Name & Hospital Name & Condition Patient Address Address Condition Patient Address Practitioner's Name & Hospital Name & Condition Patient & degree of recovery Practice	coverage? If "Yes", w	hat is the total amount of	f coverage already	in-force? \$_				
No. Patient Address Address Condition treatment & degree of recovery  I authorize any physician, medical practitioner, hospital, clinic, other health facility, the MIB, Inc., 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 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 agree that this authorization will be valid for two and one half years from the date shown below and have read, understand, and accept the statements and provisions on the reverse side of this application.  Signature of Employee x  Date	For each "Yes" answer to o	uestions 1 through 5b			ue on revers	se side if additi	mntome	
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oignatare of Employee A	have read, understand, and acce	ept the statements and pro	visions on the reverse	e side of this ap	oplication.	or two and one na	iii years nom me date	SHOWN DELOW BITCH
Signature of Spouse x Date	Signature of Employee x						Date	
	Signature of Spouse x						Date	
ENDORSEMENT (GUARDIAN USE ONLY)	The state of the s							
Employee: Approved Declined Premium Class: Preferred Standard Child: Approved Declined	Employee: Approved	Declined Premium Cla	ass: 🔲 Preferred	Standard				
Optional Life: \$ Guardian's Universal Life: \$ Optional Life: \$ Child Term Rider: \$	Optional Life: \$	Guardian's l	Universal Life: \$			Life: \$	Child Term I	
Spouse: Approved Declined Premium Class: Preferred Standard Excess Life	Spouse: Approved D	eclined Premium Cla	ass: Preferred	Standard				=
Optional Life: \$ Spouse Term Rider: \$ Long Term Disability \$ Approved Declined Short Term Disability \$ Approved Declined	Optional Life: \$	Spouse Ten	m Rider: \$		_	•		
Short Term Disability \$ Approved Declined Declined Declined Declined		· I	Bv:			III DISABIlITA \$_		en [] Decimen
Stuart J. Shaw			•					T. Shaw

I hereby represent that the statements and answers to the questions on the reverse side 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.

"It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

I understand The Guardian Life Insurance Company of America 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 MIB, Inc., 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 Guardian's notice regarding its insurance information practices, and medical records.

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

## Read and Detach for your records

Thank you for choosing Guardian insurance. This 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. If you wish a more detailed explanation of our information practices, please send your written request to Corporate Secretary, The Guardian Life Insurance Company of America, 7 Hanover Square, New York, NY 10004-4025.

MIB, Inc., Pre-Notice: "Information regarding your insurability will be treated as confidential. Guardian, or its reinsurers may, however, make a brief report thereon to MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB, Inc., Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file."

"Upon receipt of a request from you MIB, Inc., will arrange disclosure of any information it may have in your file. Please contact MIB, Inc., at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of information in MIB, Inc., file, you may contact MIB, Inc., and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc., information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734."

"Guardian, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted." Information for consumers about MIB, Inc., may be obtained on its website <a href="https://www.mib.com">www.mib.com</a>

**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.

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 Insurance Company's expense), that I be examined by an accredited medical examiner selected by the Company, (2) no Group Insurance shall 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.

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I authorize any physician, medical practitioner, hospital, clinic, other health facility, the MIB, Inc., 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 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 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 MIB, Inc., 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 Guardian's notice regarding its insurance information practices, and medical records.

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