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

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

Planholder Name (Company Name)	Group Plan No.

Complete the following information for each person to be underwritten:

Name (Last, First, Middle Initial)	Sex	Birthdate	Height	Weight	Full Time Student?
Employee:	☐ M ☐ F				
Spouse:	☐ M ☐ F				
Child:	☐ M ☐ F				☐ Yes ☐ No
Child:	☐ M ☐ F				☐ Yes ☐ 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; or been advised to have treatment for drug abuse (including prescription drugs); or alcoholism?	**Employee** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No **Child** ☐ Yes ☐ No
2. In the past 5 years used illegal drugs?	**Employee** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No **Child** ☐ Yes ☐ No
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 (thrush); lymphadenopathy (enlarged or swollen glands)?	**Employee** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No **Child** ☐ Yes ☐ No
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 medication(s) - (other than for colds, flu or allergies)?	**Employee** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No **Child** ☐ Yes ☐ No
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? $_____	**Employee** ☐ Yes ☐ No

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

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 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 I have read, understand, and accept the statements and provisions on the reverse side of this application.

Signature of Employee x **Date**

Signature of Spouse x **Date**

ENDORSEMENT (GUARDIAN USE ONLY)

Employee: ☐ Approved ☐ Declined Premium Class: ☐ Preferred ☐ Standard Optional Life: $ Guardian's Universal Life: $	**Child:** ☐ Approved ☐ Declined Optional Life: $ Child Term Rider: $
Spouse: ☐ Approved ☐ Declined Premium Class: ☐ Preferred ☐ Standard Optional Life: $ Spouse Term Rider: $	Excess Life $_____ ☐ Approved ☐ Declined Long Term Disability $_____ ☐ Approved ☐ Declined Short Term Disability $_____ ☐ Approved ☐ Declined

Effective Date:	By:	Date:	Secretary

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.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

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 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 Guardian's notice regarding its insurance information practices, and medical records.

*** 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