

MEMBER ENROLMENT FORM & HEALTH HISTORY QUESTIONNAIRE EB 187





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	EMPLOYER USE v. No.	EMPLOYER/	COMPANY	NAME										
LOCATION		Ef	MPLOYME	NT DATE			EFFECTI	VE DATE	*			NEW H	RE	
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MEMBER No. ¹	OCC	UPATION												
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Work Tel. No. ()—)—			Cellular No). ()—]-[_						
HOME ADDRESS														
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L-mail Address														
		GROU	P HEAL	TH ONL	Υ.									
DEPENDENTS														
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SALARY P.A.	GROUP LIFE, G		SONAL			PENS	SION C	ONLY						
		ROUP PER % VOLU		ACCIDE		PENS	SION C	ONLY						
SALARY P.A.	ensionable salary)	% volu	NTARY	%	ó				oe any co	mpetent	adult or ir	nstitution.		
SALARY P.A. PENSION CONTRIBUTION: BASIC (5% of p	ensionable salary)	% VOLU	NTARY nanage the ins	urance proceed	ó	alf of the mi			oe any co	mpetent	adult or ir	nstitution.		
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SALARY P.A. PENSION CONTRIBUTION: BASIC (5% of properties of the designated beneficiary is a minor beneficiary NAME TRUSTEE NAME: TRUSTEE NAME: TRUSTEE NAME: TRUSTEE NAME: I elect coverage on behalf of myself ar contributions required (if any) for the coverage of t	ensionable salary) r, you are required to appoint RELATIONSHIP and my eligible dependence erage. e applicable, to have a covered dependent.	## VOLUITE ATTUSTED WHO WILLING TO A TRUSTED WHO WILLING TO A TRUSTED WHO WILLING THE ATTUSTED WHO WILLING WHO WILLING THE WILLING THE WILLING THE WILLING THE WILLING THE	nanage the ins PENSION (%) d above (where app	M M M M M M M M M M M M M M M M M M M	TH Y Y Y Y Y And autital or oth	M F M F M F	ny emp	loyer t	o dedu	TRN		e diagn	nosis,
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HEALTH HISTORY QUESTIONNAIRE

All information contained in this questionnaire is strictly confidential.

	ealth Histo	ory questionium e is being t	ompieted for.	MPLOYEE ONLY	EMPLOY	EE & DEPENDENTS	DEPENDENTS ONLY
		NAME	RELATIONSHIP	HEIGHT	D D D D D D D D D D D D D D D D D D D	SEX M M Y Y M F	TRN
			PE	RSONAL HE	ALTH HISTOR	Y	
		(NOTE: IF QUESTIONNA	IRE IS BEING CO	MPLETED FOR	NEW DEPENDE	NTS, GIVE DETAILS (ONLY FOR DEPENDENTS.)
FOR T	HE EMPLO	DYEE					YES NO
1. Ar	e you emp	loyed by the employer nam	ed on this form fo	r more than 30	hours every week	?	
		YEE AND/OR DEPENDENTS					
	_	t 5 years, have you or any o c tests (e.g. blood tests, X-R			en examined or tre	ated by a Doctor, or b	een advised to have
	ring the lastitution?	st 5 years, have you or any c	f your dependents	s undergone a s	urgical operation,	or been treated in any	hospital or other
Kid not	ney Disord listed any	ny of your dependents beer ler, Diabetes, Tuberculosis, where on this application? 'line/state disease.)					
	ve you or a derline dis	ny of your dependents beer ease.)	n diagnosed with,	or treated for H	IV, AIDS, or ARC (A	NDS related complicati	ons) (If 'Yes;
	-	y of your dependents now rataking any medication?	eceiving, contemp	lating, or been a	advised to seek an	y medical attention or	surgical
		of your dependents have a	ny disorder of the	female organs o	or breast?		
8. Are	you or an	y of your dependents now p	oregnant?				
9. Do	you or any	of your dependents have a	ny physical impair	rments?			
11. Ha	ve you or a	y of your dependents have a any of your dependents eve n any way?			_		d
		ONSE TO ANY OF QUESTIO		NATURE OF		CONTINUE ON ANOTH	IER SHEET, IF NECESSARY) NAME AND ADDRESS OF ATTENDING
QUES- TION	DATE OF ILLNESS	FULL NAME OF PERSON I	REATED	NATURE OF	AILIVIENI	DEGREE OF RECOVERY:	NAME AND ADDRESS OF ATTENDING
NO.						(FULL, PARTIAL OR CONTINUING)	PHYSICIAN OR DENTIST
NO.						(FULL, PARTIAL OR	PHYSICIAN OR DENTIST
NO.						(FULL, PARTIAL OR	PHYSICIAN OR DENTIST
NO.						(FULL, PARTIAL OR	PHYSICIAN OR DENTIST
NO.						(FULL, PARTIAL OR	PHYSICIAN OR DENTIST
I decla effect medic exami	ive. I autho al history,	orize the physician, hospital as well as that of any de a Physician of their choice to	or other medicall pendents listed al	ly related facility bove. It is furth	y to disclose to Gu ier understood th	(FULL, PARTIAL OR CONTINUING) they form the basis upparation Life Limited in	physician or dentist from which any insurance will be made formation about my health, habits or the reserves the right to request an ed reserves the right to request an edge of the right to request and edge of the right to request an edge of the right to request and edge of t
I decla effect medic exami	ive. I autho al history, nation by	orize the physician, hospital as well as that of any de a Physician of their choice to ployee	or other medicall pendents listed al paid its decision.	ly related facility bove. It is furth	y to disclose to Gu ier understood th	they form the basis up ardian Life limit at Guardian Life limit	on which any insurance will be made formation about my health, habits or red reserves the right to request an
I decla effect medic exami Signa 1. Is t	ive. I authory, nation by sture of Employers the employers the employers the emp	orize the physician, hospital as well as that of any de a Physician of their choice to	or other medicall pendents listed all paid its decision. D BY THE EM hable to perform lick for more than 1	y related facility bove. It is furth PLOYER (Will his/her duties? week due to side	y to disclose to Gu ner understood th hen the quest ckness or injury du	they form the basis up ardian Life Limited in at Guardian Life limited. Date	on which any insurance will be made formation about my health, habits or ed reserves the right to request an employee) YES NO If YES give details
I decla effect medic exami Signa 1. Is 1 2. Ha 3. Do	ive. I authory, nation by the employ s the employ by you know	orize the physician, hospital as well as that of any de a Physician of their choice to bloyee TO BE COMPLETE yee absent from work and use to be a physician of their choice to	or other medicall pendents listed all paid its decision. D BY THE EM nable to perform lick for more than 1 ous physical impa	PLOYER (Whis/her duties? week due to sidirment, history d	y to disclose to Gu ner understood th hen the quest ckness or injury du	they form the basis up ardian Life limit at Guardian Life limited in at Guardian Life limit pate to the ring the past 6 months lcoholism?	on which any insurance will be made formation about my health, habits or ed reserves the right to request an employee) YES NO If YES give details