Guardian®

The Guardian Life Insurance Company of America

And its Affiliates and Subsidiaries
P.O. Box 14319, Lexington, KY 40512

Evidence of Insurability Form

This form can be completed at guardiananytime.com/eoi.

Planholder Name:	Group Plan Number: _____

Complete the following information for each person seeking coverage:

Name (Last, First, Middle Initial)	Sex	Birthdate	Height	Weight	Full time Student
Member:	☐M ☐F				
Spouse /Partner (Wherever the term spouse appears on this form, it also includes partner.):	☐M ☐F				
Child:	☐M ☐F				☐ Yes ☐ No
Child:	☐M ☐F				☐ Yes ☐ No
Child:	☐M ☐F				☐ Yes ☐ No
Child:	☐M ☐F				☐ Yes ☐ No

Continue on reverse side if additional space is needed for additional child(ren).

Member Home Address: City: State: Zip Code:	Member Cell Phone:	Member Telephone Number:
Date of Hire:	Planholder Provided Identification:	Personal Email Address:
Member's Social Security Number: Your Social Security Number must be provided if enrolling for Life Coverage, Short-Term Disability Coverage and/or Long-Term Disability Coverage.	Date of Marriage/Union:	Member's Place of Birth (State):
Member Amount of Insurance Currently In Force:	Spouse Amount of Insurance Currently In Force:	Child Amount of Insurance Currently In Force:
Member Insurance Amount Elected: ☐ Basic Life $_____ ☐ Voluntary Term Life $_____ ☐ Short-Term Disability $_____ ☐ Long-Term Disability $_____	Spouse Insurance Amount Elected: ☐ Basic Life $_____ ☐ Voluntary Term Life $_____	Child Insurance Amount Elected: ☐ Basic Life $_____ ☐ Voluntary Term Life $_____

IF APPLYING FOR LIFE INSURANCE: Questions 1-4 must be answered for each person applying for coverage.

IF APPLYING FOR DISABILITY INSURANCE: All five questions must be answered by the member.

1. In the past 10 years, has any proposed insured been treated for or diagnosed by a medical professional as having any of the following: a) any heart disease (including but not limited to cardiomyopathy, coronary artery disease, heart murmur); liver disease (including but not limited to hepatitis, liver failure, liver cirrhosis), kidney disease (including but not limited to end stage renal disease, kidney failure); lung or respiratory system disease (including but not limited to emphysema, chronic obstructive pulmonary disease (COPD), idiopathic pulmonary fibrosis or cystic fibrosis); b) any	Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No Child ☐ Yes ☐ No

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digestive system disease of your esophagus, stomach, or intestines (including but not limited to Crohn's disease, hepatitis, ulcerative colitis); c) any mental, nervous, emotional or neurological(including but not limited to depression or Bipolar disorder); d) autoimmune disease (including but not limited to autoimmune anemia, thyroid disorder, rheumatoid arthritis); e) diabetes; f) cancer; or g) a stroke?	
2. In the past 5 years, has any proposed insured: used(1) opiates, (which includes opium, morphine, codeine, heroin, or opiods); (2) central nervous system depressants (which includes barbituates, nonbarbituate depressants or sedatives and benzodiazepines); (3) central nervous system stimulants (including cocaine and amphetamines); (4) hallucinogens; or (5) cannabis; used prescription medication other than as prescribed; been treated for alcoholism or drug use or dependency; or been advised by a medical professional to seek treatment for alcoholism, drug abuse or drug dependency?	Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No Child ☐ Yes ☐ No
3. Has any proposed insured ever been treated for or diagnosed by a medical professional as having AIDS Related Complex (ARC) or AIDS?	Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No Child ☐ Yes ☐ No
4. In the past year, has any proposed insured: (a) been treated for or diagnosed by a medical professional for any illness, injury, or disease NOT listed in the questions above (including routine physicals only when there is an existing or newly diagnosed medical condition); or (b) sought treatment in a hospital or other health care facility for evaluation, diagnosis, treatment or an operation; undergone any diagnostic testing including but not limited to X ray, blood work, ultrasound, an MRI, a CT scan, or PET scan; or been prescribed medication(s) – (other than for colds, flu or allergies)?	Member ☐ 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, have you been treated for any disease of the back, neck, spine including but not limited to degenerative disc disease, spinal stenosis or Spina Bifida; arthritis; or any musculoskeletal disorder (including but not limited to Repetitive Strain Injury, Carpal Tunnel Syndrome, Bursitis and Tendonitis)? (b) Are you currently pregnant?	Member ☐ Yes ☐ No Member ☐ Yes ☐ No

For each "yes" answer to question 1 through 5 give details below. (Continue on reverse side if additional space is needed.)

Question #	Name of Patient	Doctor/Hospital Name and Address	Condition, Injury, Test or Operation	Duration of Symptoms, Treatment, and Degree of Recovery	Dates of Onset and Recovery

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Representations of the Proposed Insured(s)

Please read and sign below.

Those parties who sign below hereby represent that the statements and answers to the question(s) are, to the best of the knowledge and belief of the party signing below, full, complete, true and correctly recorded. Those parties who sign below understand that they will form the basis of any coverage under the Group Plan for which Evidence of Insurability is required. When used in this section, "I" refers to the person applying for insurance signing below.

Also, it is mutually understood and agreed that:

(1) Guardian (Guardian referred to herein is The Guardian Life Insurance Company of America, and/or other subsidiaries and affiliates) may request, at its expense (except in the case of a late entrant, it is not at Guardian's expense), that any proposed insured be examined by an accredited medical examiner selected by Guardian;

(2) no Group Insurance will be binding or in force until satisfactory evidence of insurability is submitted, approved by Guardian and the required premiums are received by Guardian; and:
(a) I am actively at work on a full-time basis (i.e., regularly working at least the number of hours in the normal work week set by the employer at the employer's place of business) for full pay on the date my Group Insurance becomes effective; otherwise, (b) I 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 family members will not take effect if a family member other than a newborn is:
(a) confined to the hospital or other health care facility (i.e., any day for which room and board is charged by the institution); or
(b) unable to move about, to dress, to maintain personal hygiene, to feed oneself, to work/play for someone of like age and sex;

(4) no person, except the President, a Vice President or a Secretary of Guardian, 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 Guardian's requirements;
(c) bind Guardian 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 planholder is hereby named the proposed insured's representative for the purpose of receiving premiums and remitting them to Guardian. In the event Guardian receives premiums in excess of the appropriate amount for the coverage provided, Guardian will only be liable for the overpaid premiums plus applicable interest.

This Evidence of Insurability Form ("EOI") is considered a part of the Group Policy through which you are applying for coverage.

The falsity of any statement in the application for this coverage shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affects either the acceptance of the risk or the hazard assumed by The Guardian Life Insurance Company of America.

In these circumstances, Guardian's sole responsibility will be to return premium(s) submitted for the coverage(s).

The state in which you reside may have a specific state fraud warning. Please refer to the Fraud Warning Statements page.

By my signature below, I agree with all of the terms, conditions, statements, and representations stated above in Representations of the Proposed Insured(s).

_____ _____
Signature of Member Date

_____ _____
Signature of Spouse Date

_____ _____
Signature of Child age 18 and over Date

_____ _____
Signature of Child age 18 and over Date

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Authorization to Obtain and Release Information

This Authorization Is Designed to Comply with The Health Insurance Portability Act of 1996 as amended (HIPAA) Privacy Rule.

This Authorization applies to the proposed insured. It can only be signed by the proposed insured, or the parent or legal guardian of the proposed insured in the case of a minor under the age of 18.

I hereby authorize the disclosure and/or release of all the information below to Guardian (Guardian referred to herein is The Guardian Life Insurance Company of America, and/or other subsidiaries and affiliates), its service providers, employees, or to its legal representatives.

Medical Records and other information. I authorize any physician, medical or mental health professional, practitioner, provider, hospital, clinic, other health or medical facility, laboratory, pharmacy, pharmacy benefit manager, therapist, health plan, benefit plan administrator, electronic health record provider, consumer reporting agency or other reporting agency, governmental agency, the Veteran's Administration, the Social Security Administration, the Department of Motor Vehicles, state agency, MIB, LLC, insurance or reinsurance company (including Guardian), or employer to disclose and/or release any and all medical and non-medical information, whether in paper or in electronic format, in its possession about the proposed insured. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, pharmaceutical history, mental or physical condition, diagnosis, or treatment of the proposed insured. Non-medical information includes information such as credit reports, consumer reports, employment, occupation, payment records, financial information or records, and/or publicly accessible sources. The information outlined above may be provided by those listed above and/or compiled and interpreted by third parties.

I acknowledge that any agreements I have made to restrict my health information do not apply to this Authorization and I instruct any physician, health care professional, provider, hospital, clinic, health or medical facility, other health care provider or health plan, insurer, or other entity to disclose my entire medical record without restriction. I understand that the information released could contain reference to or results of sexually transmitted diseases, genetic testing or genetic information and may relate to the symptoms, evaluation, diagnosis, examination, treatment or prognosis of any mental or physical condition, including psychiatric, and psychological conditions, and drug or alcohol abuse.

I know that I may be requested to be interviewed in connection with the preparation of these medical records and other information. **I know** that I may request and receive a copy of these medical records and other information.

I agree that this Authorization shall be valid for twenty-four (24) months from the date shown below. However, this time limit may be shorter if the time period permitted by applicable law in the state where the policy is delivered or issued for delivery is less. I agree that a copy of this Authorization shall be as valid as the original. I agree that if I sign this Authorization electronically, including via voice Authorization, that it will be equally as effective and valid as if I signed the form through traditional means. I understand, however, that I am under no obligation to sign this document electronically.

I know that I may revoke this Authorization in writing, at any time, by sending a written request for revocation to the Chief Underwriter at The Guardian Life Insurance Company of America, P.O. Box 14319, Lexington, KY 40512. I understand that a revocation is not effective to the extent that Guardian and/or any of the entities listed above has already relied on this Authorization, or to the extent that Guardian has a legal right to contest a claim under an insurance policy or to contest the policy itself.

I understand that Guardian or its legal representatives will use the information obtained by this Authorization in connection with underwriting my application for insurance, to determine eligibility for insurance, to determine the premium for the insurance, to obtain reinsurance, to service any insurance issued, to administer coverage, to evaluate any claim for insurance benefits, to determine eligibility for benefits under an existing policy, and to conduct any other legally permissible activities that relate to any existing coverage, coverage that I have applied for, or may in the future apply for with Guardian. In addition to the above, Guardian or its legal representative may use the information to perform actuarial or research studies, analytics, review internal processes or experience, and/or conduct a legally permissible contestability review. Any misrepresentation or omission, if found to be material, may adversely affect acceptance of the risk, claims payment, or may lead to rescission of any policy issued. I further understand that if I refuse to sign this Authorization, Guardian may not be able to process my application, or pay a claim in the case of coverage which is already in force. Providers of health care services may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. Guardian or its legal representatives will not release any information obtained relating to HIV or AIDS/ARC status to any person or organization. Guardian will not release any other information obtained using this Authorization to any person or organization except to reinsurance companies, MIB, LLC, or other persons, agencies, companies or organizations performing business or legal services in connection with an application, claim, to perform actuarial or research studies perform analytics, or in evaluating our internal processes or experience or as may be lawfully permitted or required, or as I may further authorize. I understand that any information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no

longer be protected by federal regulations governing privacy (such as the HIPAA Privacy Rule). If I am applying for insurance and/or have existing coverage with Guardian, information collected to determine eligibility for insurance and/or for benefits under an existing policy will be shared by Guardian. However, I also understand that Guardian may deidentify and aggregate my information to create insights about medical trends amongst various populations. This information will not personally identify me. I further understand that any policy issued will be delivered to the policy owner, which may be a party other than the proposed insured, and that this Authorization may become part of any policy issued.

I authorize Guardian or its legal representatives to make a brief report of my personal health information to the MIB, LLC.

I acknowledge that I have been given a copy of this Authorization and also acknowledge receipt of the Notice of Insurance Information Practices, which includes the Fair Credit Reporting Act Pre-Notice, the MIB Pre-Notice, and Medical Records. I also acknowledge that I or an individual authorized to act on my behalf is entitled to receive an additional copy of this Authorization. Any alteration of this Authorization will not be accepted.

_____	_____
Signature of Member	Date
_____	_____
Signature of Spouse	Date
_____	_____
Signature of Child age 18 and over	Date
_____	_____
Signature of Child age 18 and over	Date

Notice of Insurance Information Practices

Please read and detach for your records

Thank you for choosing The Guardian Life Insurance Company of America ("Guardian"). This notice is given to you at the time you apply for life or disability 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, except as authorized by you, or as required by law. 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: The Privacy Office, The Guardian Life Insurance Company of America, 10 Hudson Yards, New York, NY 10001.

MIB, LLC Pre-Notice: Information regarding your insurability will be treated as confidential. Guardian, or its reinsurers may, however, make a brief report thereon to MIB, LLC, 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, LLC member company for life, health or disability insurance coverage, or a claim for benefits is submitted to such a company, MIB, LLC, upon request, will supply such company with the information about you in its file.

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

Guardian, or its reinsurers, may also release information in its file, except information relating to HIV or AIDS/ARC status, to other insurance companies to whom you may apply for life, health, or disability insurance, or to whom a claim for benefits may be submitted.

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.

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Fraud Warning Statements

The laws of several states require the following statements to appear:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kansas: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially false information, or conceals for purpose of misleading information concerning any fact material hereto, may be guilty of committing a fraudulent insurance act as determined by a court of law, which may be a crime, and may also be subject to civil penalties, or denial of insurance benefits.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinements in prison.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefit.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Missouri: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any knowingly false information, or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits subject to the conditions/provisions of the policy.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

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New York: The laws of New York require the following statement appear: 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.)

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

Oklahoma: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially false information, or conceals for purpose of misleading information concerning any fact material hereto, may be committing a fraudulent insurance act, and may be subject to civil penalties, or denial of insurance benefits.

Pennsylvania: 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 subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Tennessee and Washington: 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.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to the penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

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