GUARDIAN® **The Guardian Life Insurance Company of America**

And its Affiliates and Subsidiaries

☐ P.O. Box 14319
Lexington KY 40512

EVIDENCE OF INSURABILITY SUPPLEMENTAL FORM

Please complete this form 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)	
Employee:	
Spouse	
Child	
Child	

The following information was omitted from the Evidence Of Insurability Form EOI2012. Please provide responses to the following questions. All questions should be answered by each person applying for coverage. However, if applying for coverage for a child, the Employee must complete questions for the child applying for coverage.

If you or your dependent spouse, elect Critical Illness Coverage you must answer the following health questions.

1. Has any proposed insured been diagnosed with or treated by a medical professional for any of the following conditions: cancer, carcinoma in situ, malignant melanoma, tumor (benign or malignant) , Barrett's esophagus, Crohn's disease, ulcerative colitis, blood disorder (other than AIDS or HIV), any chronic or progressive disease of kidneys, liver (including hepatitis), lungs, including emphysema and COPD**,** pancreas or bone marrow? Or, been advised to have an organ transplant, including bone marrow or stem cell transplant?
Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No

2. Has any proposed insured been diagnosed with or treated by a medical professional for heart attack**,** heart disease or coronary artery disease, stroke or transient ischemic attack (TIA), or been advised to have bypass surgery, stent insertions treatment for coronary arteries?
Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No

3. Has any proposed insured been diagnosed with or treated by a medical professional for uncontrolled blood pressure (requiring a change in medication or dosage in the past 6 months or been diagnosed with or treated for diabetes (except if present only in pregnancy)?
Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No

4. Has any proposed insured been diagnosed with or treated by a medical professional for any progressive vision, speech or hearing disorder, or dementia (including Alzheimer's disease) or any neurological disease or disorder, including seizures, [1]Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease), Huntington's disease, Multiple Sclerosis or Parkinson's Disease?
Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No

5. Has any proposed insured been diagnosed with or treated by a medical professional for AIDS (acquired immune deficiency syndrome), AIDS-Related Complex or tested positive for HIV (human immunodeficiency virus)?
Employee ☐ Yes ☐ No Spouse ☐ Yes ☐ No

Please retain a copy for your records and submit this form to Guardian

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 Part , "I" refers to the person applying for insurance signing below.*

Also, it is mutually understood and agreed that (1) the Company reserves the right to request, at its expense (except in the case of a late entrant, it is not at the Company's expense), that any proposed insured 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, approved by the Company and the required premiums are received by the Company; 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 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. In the event the Company receives premiums in excess of the appropriate amount for the coverage provided, the Company will only be liable for the overpaid premiums plus applicable interest.

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 coverage issued based on this Evidence of Insurability Form.

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

_____ _____

Signature of Employee *Date*

_____ _____

Signature of Spouse *Date*

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