Guardian Group
Guardian Life Limited

MEMBER ENROLMENT FORM
& HEALTH HISTORY QUESTIONNAIRE
EB 187

12 Trafalgar Road, Kingston 5, Jamaica W. I.
Tel: (876) 978-4473 Fax: (876) 927-4732
Toll Free: 1-888-633-3287 Website: www.myguardiangroup.com

Guardian HEALTH

FOR EMPLOYER USE

POLICY No. | Div. No. | EMPLOYER/COMPANY NAME

LOCATION | EMPLOYMENT DATE (dd/mm/yyyy) | EFFECTIVE DATE* (dd/mm/yyyy) | NEW HIRE Y N

REMARKS

MEMBER NAME (First) [3] | MI [3] | (Last) [3]

MEMBER No. [1] | OCCUPATION

DATE OF BIRTH | PROOF OF AGE ☐ Birth Certificate attached ☐ Other | GENDER M F | MARITAL STATUS* Ma Si Di Wi Se Co

*Ma – Married; Si – Single; Di – Divorced; Wi – Widowed, Se – Separated, Co – Common law

TRN [2] | Home Tel. No.

Work Tel. No. | Cellular No.

HOME ADDRESS

E-mail Address

GROUP HEALTH ONLY

DEPENDENTS

SURNAME	FIRST NAME	MI	SEX	RELATIONSHIP	DATE OF BIRTH	TRN
			M F			
			M F			
			M F			
			M F			
			M F			

GROUP LIFE, GROUP PERSONAL ACCIDENT & PENSION ONLY

SALARY P.A.

PENSION CONTRIBUTION: BASIC (5% of pensionable salary) % VOLUNTARY %

TRUSTEE – If the designated beneficiary is a minor, you are required to appoint a trustee who will manage the insurance proceeds on behalf of the minor. The trustee may be any competent adult or institution.

BENEFICIARY NAME	RELATIONSHIP	LIFE (%)	PENSION (%)	DATE OF BIRTH (dd/mm/yyyy)	SEX	TRN
					M F	
TRUSTEE NAME:						
					M F	
TRUSTEE NAME:						
					M F	
TRUSTEE NAME:						
					M F	
TRUSTEE NAME:						
TRUSTEE NAME:					M F	

I elect coverage on behalf of myself and my eligible dependent(s) as listed above (where applicable) and authorize my employer to deduct from my earnings the contributions required (if any) for the coverage.

I authorize Guardian Life Limited, where applicable, to have access to, and copies of, all medical, hospital or other institution/agency records relating to the diagnosis, treatment or services provided to me or a covered dependent.

SIGNATURE OF EMPLOYEE | DATE

NAME OF AUTHORIZED OFFICER OF EMPLOYER | SIGNATURE OF AUTHORIZED OFFICER OF EMPLOYER | POSITION OF AUTHORIZED OFFICER OF EMPLOYER

COMPANY STAMP | DATE

(If employee is applying for coverage outside of eligibility period, please complete the Health History Questionnaire on the overleaf)