

PART C (cont'd)

SECTION B - in addition to the conditions listed in SECTION A, to the best of your knowledge and belief has any person named in this application:

- (a) Had a check-up, consultation, illness, injury or surgery?
- (b) Had any mental or physical disorder not listed above?
- (c) Been advised to have any diagnostic test, hospitalization, or surgery which was not completed?

Yes	No	Yes	No	Yes	No	Yes	No
EMP		SPOUSE		CHILD		CHILD	

1. SECTION C - If you have checked "YES" to any part of SECTION A or SECTION B, please provide complete information regarding diagnosis, symptom(s) or treatment (including all hospitalization, surgery, and diagnostic testing, results) and dates. If more space is needed, attach a separate sheet of paper.

Patient's Full Name	Diagnosis/Symptom	Duration Dates		Details	Recovery	
		From	To		Check only one box.	
					Full	Partial
					Full	Partial
					Full	Partial
					Full	Partial
					Full	Partial
					Full	Partial

2. Are you or any dependant listed as using or expected to be using medication or serum in the next three months? INSURED SPOUSE/CHILDREN
 YES NO YES NO

If you or any dependant listed are currently using medication or serum complete section below.

Name of Person	Name of Drug/Medication or Serum	Monthly cost of Drug/Medication or Serum	Strength of Drug or Medication	Daily Dosage of Drug/Medication or Serum	Length of time on Drug/Medication or Serum

DECLARATION
All applicants must complete

NOTE THE INFORMATION ON THIS FORM IS TO BE CONSIDERED CONFIDENTIAL.

I/We hereby declare that the answers given and recorded herein are, to the best of my/our knowledge, complete and true at this date.

I/We hereby authorize any licensed physician, medical practitioner, hospital, clinic, medical facility or organization which has records of my/our health records of my/our health to release such information to Guardian Life of the Caribbean Limited. A photocopy of this signed authorization shall be as valid as the original.

I/We understand and agree that any injury that occurred on or before the date of this application or any sickness, the signs of which first appeared on or before the date of this application, are not covered by this contract unless fully disclosed on this application. Failure to disclose such information could result in denial of a claim and the cancellation of coverage.

I/We understand and agree that coverage shall not become effective until approved by Guardian Life of the Caribbean Limited.

Signature of Insured Siganture of Spouse

Dated/...../..... Dated/...../.....
 Day Month Year Day Month Year