GUARDIAN LIFE LIMITED
LOOKING AFTER LIFE
A MEMBER OF THE GUARDIAN HOLDINGS GROUP

HEALTH HISTORY QUESTIONNAIRE

All information contained in this questionnaire is strictly confidential.

MedeCus HEALTH
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Toll Free: 1-888-MEDECUS
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EMPLOYER

GROUP POLICY NUMBER:

LAST NAME | FIRST NAME | M.I. | EMPLOYEE'S DATE OF BIRTH (D D M M Y Y)

OCCUPATION | DATE EMPLOYED (DD / MM / YY) | F | M

This Health Questionnaire is being completed for: Employee Only ☐ Employee & Dependents ☐ Dependents Only ☐

NAMES OF ELIGIBLE DEPENDENTS (SPOUSE/CHILDREN)	RELATIONSHIP TO EMPLOYEE	HEIGHT	WEIGHT	Date of Birth

PERSONAL HEALTH HISTORY

For the Employee

(Note: If questionnaire is being completed for new dependents, give details only for dependents.)

	YES	NO
1. Are you employed by the employer named on this form for more than 30 hours every week?	☐	☐

For the Employee and/or Dependents kindly respond 'YES' or 'NO' to the following questions.

	YES	NO
2. During the last 5 years, have you or any of your dependents consulted, been examined or treated by a Doctor, or been advised to have any diagnostic tests (e.g. blood tests, X-Rays, CAT Scan, MRI) etc.?	☐	☐
3. During the last 5 years, have you or any of your dependents undergone a surgical operation, or been treated in any hospital or other institution?	☐	☐
4. Have you or any of your dependents been treated for, or been told that you have Heart Trouble, Blood Disease, High Blood Pressure, Kidney Disorder, Diabetes, Tuberculosis, Cancer, Tumor, Ulcer, Asthma, Epilepsy, Alcoholism, Mental Disorder, or any other disease not listed anywhere on this application? (If 'Yes' underline disease. If 'No' state disease.) _____	☐	☐
5. Have you or any of your dependents been diagnosed with, or treated for HIV, AIDS, or ARC (AIDS related complications) (If 'Yes' underline disease).	☐	☐
6. Are you or any of your dependents now receiving, contemplating, or been advised to seek any medical attention or surgical treatment, or taking any medication?	☐	☐
7. Do you or any of your dependents have any disorder of the female organs or breast?	☐	☐
8. Are you or any of your dependents now pregnant?	☐	☐
9. Do you or any of your dependents have any physical impairments?	☐	☐
10. Do you or any of your dependents have any prior or existing history of alcoholism or drug abuse?	☐	☐
11. Have you or any of your dependents ever had an application for Life or Health Insurance declined, postponed, rated or modified in any way?	☐	☐

If the response to any of questions 2 - 11 is 'YES', give complete details below (continue on the reverse side or another sheet if necessary)

Question No.	Full Name of Person Treated	Nature of Ailment	Date(s) of Visit(s)	Degree of Recovery: Full, Partial or Continuing	Name and Address of Attending Physician or Dentist

I declare that all the statements on this form are full, true and complete, and I understand that they form the basis upon which any insurance will be made effective. I authorize the Physician, Hospital or other medically related facility to disclose to **Guardian Life Limited** information about my health, habits or medical history, as well as that of any dependents listed above. It is further understood that **Guardian Life Limited** reserves the right to request an examination by a Physician of their choice to aid its decision.

Date _____ Signature of Employee _____

SECTION 2 TO BE COMPLETED BY THE EMPLOYER (When the questions relate to the employee)

	YES	NO	*If NO give details*
1. ☐ Is the employee now at work and able to perform all duties?	☐	☐	
2. ☐ Has the employee been absent from work for more than 1 week due to sickness or injury during the past 6 months?	☐	☐	
3. ☐ Do you know of any prior or existing serious physical impairment, history of drug abuse or alcoholism?	☐	☐	

Date _____ Signature of Employer _____ Title _____

Kindly affix the Company Stamp