



# MEMBER ENROLLMENT FORM & HEALTH HISTORY QUESTIONNAIRE

EB 187



|                                 |  |                                    |  |   |  |  |  |
|---------------------------------|--|------------------------------------|--|---|--|--|--|
| POLICY No. <input type="text"/> |  | Div. No. <input type="text"/>      |  | <b>FOR EMPLOYER USE</b>                   |  |  |  |
|                                 |  |                                    |  | EMPLOYER/COMPANY NAME<br><b>SHARP EYE</b> |  |  |  |
| LOCATION<br><b>MONTEGO BAY</b>  |  | EMPLOYMENT DATE<br><b>11 04 16</b> |  | EFFECTIVE DATE*<br><b>01 12 16</b>        |  | NEW HIRE<br><input checked="" type="checkbox"/> Y <input type="checkbox"/> N |  |
| REMARKS                         |  |                                    |  |   |  |  |  |

|   |   |   |  |
|---|---|---|--|
| MEMBER NAME (First) <sup>1</sup><br><b>JOHN</b> |   | MI <sup>2</sup> (Last) <sup>3</sup><br><b>F BROWN</b>                   |  |
| MEMBER No. <sup>1</sup> <input type="text"/>    |   | OCCUPATION <b>SECURITY GUARD</b>  |  |
| DATE OF BIRTH <b>16 09 75</b>                   | PROOF OF AGE <input checked="" type="checkbox"/> Birth Certificate attached <input checked="" type="checkbox"/> Other | GENDER <input checked="" type="checkbox"/> M <input type="checkbox"/> F | MARITAL STATUS* <input checked="" type="checkbox"/> Ma <input type="checkbox"/> Di <input type="checkbox"/> Wi <input type="checkbox"/> Se <input type="checkbox"/> Co |
| TRN <sup>2</sup> <b>111-123-456</b>             | Home Tel. No. <b>(876)-906-4000</b>   |   |  |
| Work Tel. No. <b>(876)-985-9999</b>             | Cellular No. <b>(876)-999-1234</b>  |   |  |
| HOME ADDRESS <b>18 MEMBERS WAY KINSTON 13</b>   |   |   |  |
| E-mail Address <b>jbrown@live.com</b>           |   |   |  |

| GROUP HEALTH ONLY |             |    |  |              |                 |                      |
|-------------------|-------------|----|--|--------------|-----------------|----------------------|
| DEPENDENTS        |             |    |  |              |                 |                      |
| SURNAME           | FIRST NAME  | MI | SEX  | RELATIONSHIP | DATE OF BIRTH   | TRN                  |
| <b>BROWN</b>      | <b>KARL</b> |    | <input checked="" type="checkbox"/> M <input type="checkbox"/> F | <b>SON</b>   | <b>28 01 09</b> | <input type="text"/> |
|                   |             |    | <input type="checkbox"/> M <input type="checkbox"/> F            |              |                 |                      |
|                   |             |    | <input type="checkbox"/> M <input type="checkbox"/> F            |              |                 |                      |
|                   |             |    | <input type="checkbox"/> M <input type="checkbox"/> F            |              |                 |                      |

| GROUP LIFE & PENSION ONLY  |              |          |             |               |   |     |
|--|--------------|----------|-------------|---------------|---|-----|
| SALARY P.A. <input type="text"/>   |              |          |             |               |   |     |
| PENSION CONTRIBUTION: BASIC (5% of pensionable salary) <input type="text"/> % VOLUNTARY <input type="text"/> %   |              |          |             |               |   |     |
| <b>TRUSTEE</b> - If the designated beneficiary is a minor, it is strongly recommended that you 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 | SEX   | TRN |
|  |              |          |             |               | <input type="checkbox"/> M <input type="checkbox"/> F |     |
| TRUSTEE NAME: <input type="text"/>   |              |          |             |               |   |     |
| TRUSTEE NAME: <input type="text"/>   |              |          |             |               |   |     |
| TRUSTEE NAME: <input type="text"/>   |              |          |             |               |   |     |
| TRUSTEE NAME: <input type="text"/>   |              |          |             |               |   |     |

As provided under my Employer's Group Contract with Guardian Life Limited, 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 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.

*John Brown*  
SIGNATURE OF EMPLOYEE

24/11/2016  
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)