GROUP CHANGE REQUEST AND BENEFICIARY UPDATE FORM
EB 186

12 Trafalgar Road, Kingston 5, Jamaica W. I.
Tel: (876) 978-4473 Fax: (876) 927-4732

Member / Employee Name[3]

Group No.

Member No. [1]

Employer

TRN [2](Member)

Effective Date D D M M Y Y

GROUP HEALTH ONLY

☐ **ADDITION OF DEPENDENTS** (LIST DETAILS BELOW)

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

GROUP HEALTH & LIFE

☐ **TERMINATION OF MEMBER / DEPENDENTS** (LIST DETAILS BELOW)

SURNAME	FIRST NAME	MI	SEX	RELATIONSHIP	DATE OF BIRTH	REASON
			M F		D D M M Y Y	
			M F		D D M M Y Y	
			M F		D D M M Y Y	
			M F		D D M M Y Y	
			M F		D D M M Y Y	

☐ **CHANGE OF INFORMATION** ☐ **NAME OFTHE EMPLOYEE** ☐ **DEPENDENT** ☐ **BIRTH/GENDER OF THE EMPLOYEE** ☐ **DEPENDENT**

FROM CURRENT/PREVIOUS NAME

TO

LAST NAME

FIRST NAME

DATE OF BIRTH D D M M Y Y

GENDER M F

INDICATE REASON FOR CHANGE/CORRECTION (Submit supporting documents)

☐ **MARRIAGE** ☐ **OTHER (Specify)**

GROUP LIFE & PENSION

☐ **APPOINTMENT/CHANGE OF BENEFICIARY**

I, (name of member) Date of Birth D D M M Y Y

residing at (home address of insured),

a member of the Group Life/Pension issued by Guardian Life Limited

for (name of employer),

do hereby revoke any previous designation or appointment of beneficiary(ies) with respect to the said Group Life/Pension Plan and subject to the condition set forth below, do hereby designate and appoint: ***(State full name of beneficiary(ies) and relationship to person whose life is insured; If more than one beneficiary, state here proportion for each).***

NOTE: You may name a trustee for any beneficiary. However, **if beneficiary is under age 18 years old, a trustee must be named**. Please state clearly the beneficiary for whom the trustee has been named.

BENEFICIARY NAME	RELATIONSHIP	LIFE(%)	PENSION(%)	DATE OF BIRTH	TRUSTEE NAME (if applicable)
				D D M M Y Y	
				D D M M Y Y	
				D D M M Y Y	
				D D M M Y Y	
				D D M M Y Y	

as beneficiary(ies) to receive all sums payable under the terms of the said Scheme/Plan by reason of my death.

I AGREE TO ANY CHANGE IN CONTRIBUTION NECESSITATED BY THE REQUESTED CHANGE(S) IN COVERAGE.

Signed at _____ this _____ day of _____ 20 _____

WITNESS

SIGNATURE OF EMPLOYEE

DATE

NAME OF AUTHORIZED OFFICER OF EMPLOYER

SIGNATURE OF AUTHORIZED OFFICER OF EMPLOYER

POSITION OF AUTHORIZED OFFICER OF EMPLOYER

DATE

For Official Use: Index by Group #, Member #, TRN and Name of Member.

[1a]**Group #:** [1b]**Member #:**

[2]**TRN:** [3]**Name of Member:**

HEALTH HISTORY QUESTIONNAIRE

All information contained in this questionnaire is strictly confidential.

This Health History Questionnaire is being completed for: EMPLOYEE ONLY ☐ EMPLOYEE & DEPENDENTS ☐ DEPENDENTS ONLY ☐

NAME	RELATIONSHIP	HEIGHT	WEIGHT	DATE OF BIRTH	SEX	TRN
				D D M M Y Y	M F	
				D D M M Y Y	M F	
				D D M M Y Y	M F	
				D D M M Y Y	M F	
				D D M M Y Y	M F	

PERSONAL HEALTH HISTORY

(NOTE: IF QUESTIONNAIRE IS BEING COMPLETED FOR NEW DEPENDENTS, GIVE DETAILS ONLY FOR DEPENDENTS.)

FOR THE EMPLOYEE

	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.

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/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; underlinedisease.)	☐	☐
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 ANOTHER SHEET, IF NECESSARY)

QUES-TION NO.	DATE OF ILLNESS	FULL NAME OF PERSON TREATED	NATURE OF AILMENT	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.

Signature of Employee _____ **Date** _____

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

	YES	NO	If YES give details
1. Is the employee absent from work and unable to perform his/her 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?	☐	☐	_____

_____ NAME OF AUTHORIZED OFFICER OF EMPLOYER

_____ SIGNATURE OF AUTHORIZED OFFICER OF EMPLOYER

_____ POSITION OF AUTHORIZED OFFICER OF EMPLOYER

_____ DATE

For Official Use Only: Index Member No., TRN & Name of Member