For PGL Use Only

Approved

Declined

Pending

PACIFIC GUARDIAN LIFE

Evidence of Insurability

Instructions for Employer: Complete Section 1

Instructions for Employee (Complete the required sections as indicated below.)

1. If you are providing evidence of insurability for:
   a. Employee Coverage Only- Complete Sections 2, 4, 5, 6
   b. Dependent Coverage Only- Complete Sections 3, 4, 5, 6
   c. Employee and Dependent Coverage- Complete all sections.
2. Complete the form in blue or black ink. Sign and date Sections 5 and 6.
3. Read the important "Medical Information Notice" and retain it for your records.
4. Mail to: *Pacific Guardian Life*
   Attn: Group Department
   1440 Kapiolani Boulevard, Suite 1700
   Honolulu, HI 96814-3698

Section 1: "Employer Information"

☐ Over Guarantee Issue Limit ☐ Late Enrollment ☐ Other _____

Employer Name _____ Group Policy #_____

Employer Address _____

City _____ State_____ Zip Code _____ Phone Number _____

Amount of Insurance: ☐ Basic $_____ ☐ Supplemental $_____

Section 2: "Employee Information"

Employee First Name_____ M.I._____ Last Name_____

Employee Social Security Number _____-_____-_____ Date of Hire: _____

Employee Phone Number: Daytime: ( ) _____-_____ Evening: ( ) _____-_____

Address _____ City_____ State_____ Zip Code_____

Date of Birth _____/_____/_____ Birthplace_____

Height _____Feet _____ In Weight _____ lbs. Sex ___ (M) ____ (F)

Section 3: "Dependent Information" (if applying for Dependent Insurance)

Name of Applicant _____ Social Security Number_____

Dependent's Name	Relationship	Sex	Age	Date of Birth	Place of Birth	Height	Weight

Section 4: "5 Year Medical History"

1) *During the last five years, have you:*

a. had any surgery or been advised to have surgery and have done so?	Yes___	No___
b. been in a hospital, sanitarium, or other institution for observation, rest, diagnosis, or treatment?	Yes___	No___
c. used, or are now using, cocaine, barbiturates, amphetamines, marijuana, or other hallucinatory drugs, heroin, oplates, or other narcotics except as prescribed by a doctor?	Yes___	No___
d. been treated or counseled for alcoholism?	Yes___	No___
e. been treated or counseled by a psychologist or psychiatrist	Yes___	No___
f. applied for or received disability income benefits or pension benefits on account of sickness or injury?	Yes___	No___
g. had life, disability, or health insurance declined, postponed, changed, rated-up, cancelled, or withdrawn?	Yes___	No___
h. been diagnosed by a member of the medical profession as having, or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	Yes___	No___

2) *Within the last five years, have you been treated for, or had any trouble with any of the following:*

a. heart or chest pain	Y ___ N ___	g. nervous or mental disorders	Y ___ N ___	m. urinary system	Y ___ N ___
b. high blood pressure	Y ___ N ___	h. arthritis or rheumatism	Y ___ N ___	n. goiter or glands	Y ___ N ___
c. abnormal pulse	Y ___ N ___	i. Ulcers or stomach disorders	Y ___ N ___	o. pleurisy or asthma	Y ___ N ___
d. cancer or tumors	Y ___ N ___	j. intestines or kidneys	Y ___ N ___	p. chronic diarrhea	Y ___ N ___
e. diabetes	Y ___ N ___	k. liver or gallstones	Y ___ N ___	q. neuritis or sciatica	Y ___ N ___
f. lungs	Y ___ N ___	l. genital disorder	Y ___ N ___	r. back or spinal disorder	Y ___ N ___

3) *Do you currently have any disorder, condition (including pregnancy), disease, or defect not shown above, and/or are you currently taking medication prescribed or provided by a medical or other practitioner for any disorder, condition (including pregnancy), disease, or defect?*

_____

_____

4) *Have you smoked cigarettes, used another tobacco product (including cigars or chewing tobacco) or used nicotine gum within the past year? If yes, which product?*

_____

What are the full details of all "Yes" answers to the questions above? Please attach additional pages if necessary.

Question # and letter	Specify illness or condition. Include reason for any check-up, doctor's advice, treatment, and/or medication.	Date illness or condition began Month/Year	Time lost from normal activities	Time of full recovery (if applicable) Month/Year

Section 5: "Important Notice"

IMPORTANT NOTICE:

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any Insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material.

I declare that, to the best of my knowledge and belief, the statements made in this application are complete and true. I agree that the coverage applied for is subject to the terms of the plan and shall become effective on the date or dates established by the plan provided the evidence of good health is satisfactory.

X_____ _____
Signature of Employee Date

X_____ _____
Signature of Spouse (if applicable) Date

Section 6: "Authorization for the Release of Health-Related Information"

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("my Providers") to disclose my entire medical record and any other protected health information concerning me to the Pacific Guardian Life Insurance Company, Limited (the "Company") and its agents, employees and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and Sexually Transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

This authorization also authorizes the Medical Information Bureau, Inc., any consumer reporting agency, or other insurance support organization or employer having information or records relative to the age, character, habits, avocations, finances, occupation, general reputation, credit, other insurance coverage, participation in hazardous activities, of me (us) or my (our) minor children on whom insurance is applied for, to furnish any and all such information to the Company or its reinsurers, agents, and any insurance support organization acting on its behalf for the purpose of evaluating my application for insurance.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility of coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This authorization shall remain in force for 30 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company at 1440 Kapiolani Boulevard, Suite 1700, Honolulu, HI 96814, Attention: Privacy Official. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application, or, if coverage has been issued, may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

X_____ _____ _____
Signature of Employee Social Security Number Date

X_____ _____
Signature of Spouse (if applicable) Date

NOTE: Qualifications for life insurance are determined by the amount of coverage and the age of the proposed insured. Additional tests and inquiries may be requested.

Medical Information Notice

When we evaluate your request for insurance, the state of health of the person(s) for whom insurance is requested is, of course, extremely important to us. Consequently, we need to ask you questions about the health and medical history of each person. In addition, you are also requested to authorize any physician or hospital to provide us with reports, if necessary, about the health of each person. In some instances, we may require a physical examination.

Any information we obtain regarding a person's insurability will be treated as confidential. We may, however, make a brief report of it to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. When you apply for life, disability, or health insurance to any company, which is a member of the Medical Information Bureau, or submit a claim for benefits to such a company, the Bureau will, on request, give the company the information in its files. We may reveal this information, as necessary, to a doctor, if we find a serious health problem, which you do not know about. We may also reveal this information to persons conducting mortality or morbidity studies. We will, if you ask, give you a description of other circumstances when we disclose information about you without your prior authorization.

You have the right to see any of the personal information we collect about you and to make corrections if necessary. If you ask, we will furnish you with instructions on how to exercise this right. In addition, upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If the information came from the Bureau and you question the accuracy of the Information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's Information Office is:

Medical Information Bureau
50 Braintree Hill
Suite 400
Boston, Massachusetts 02184-8734
(781) 751-6000

It is required that you be given this notice.
Please read it carefully and keep it for your records.