PACIFIC GUARDIAN LIFE

Group Life Term Insurance
Evidence of Insurability Form

Instructions for Employer: Complete Part A – Employer Information.

Instructions for Employee: Complete Part B – Employee Information as indicated below.

1. If you are providing Evidence of Insurability for:
   a. Yourself - Complete Sections 1, 2, 5, 6.
   b. Your Dependent only - Complete Sections 1, 3, 4, 5, 6.
   c. You and Your Dependent - Complete all sections.

2. Complete the applicable sections of the form in blue or black ink. Read, sign, and date Sections 5 and 6.

3. Read the "Medical Information Notice" and retain it for your records.

4. The assessment of your request for coverage may be delayed if you or your eligible dependent do not follow the instructions above, do no not provide the details requested of each question on this application or fail to sign the form.

5. Mail to: **Pacific Guardian Life**
   Attn: Group Department
   1440 Kapiolani Boulevard, Suite 1700
   Honolulu, HI 96814-3698
   Phone: (808) 942-1306; Toll-Free: 1-800-367-5354, ext. 306

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

Part A – Employer Information (This section must be completed by an Employer Representative.)

Employer Name ______________________________Group Policy No. ________________

Employer Address ____

City ______________________________ State ________________ ZIP Code __________

Contact Name ________________________Contact Phone Number____________________

	Current Amount in Force	+	Additional (or Initial) Amount Requested	=	Total Amount
Eligible Employee					
Basic Life	$__________	+	$__________	=	$__________
Supplemental Life	$__________	+	$__________	=	$__________
Eligible Dependent					
Dependent Life	$__________	+	$__________	=	$__________

Part B – Employee Information

Section 1. Employee Information

Employee First Name ____________________________________ M.I. ______ Last Name _________________________

Employee Social Security Number __________-________ - _____________Date of Hire____________________________

Employee Phone Number: Daytime: ________________________________Evening: ______________________________

Employee Address ____

City ____ State __________________________ ZIP Code ______________

Date of Birth___________ /_________ / ____________ Birth Place _____________________________________

Height_____________ ft. ______________ in. Weight ________________ lbs. Sex ____ M _____F

*If this Form is for Your Eligible **Dependent** ONLY, please skip to Section 3.

Section 2: Employee's Five Year Medical History

Employee Name____

1) Have you during the last **five** years: **(Check Yes or No)**

Please provide full details of all "Yes" answers under (6) on Page 3.

a. Undergone surgery, or were advised to have surgery and have done so? a. Yes _____ No ____

Reason: ____

b. Been admitted to a hospital, sanitarium, or other institution for observation, rest, diagnosis, or treatment? b. Yes _____ No ____

Reason: ____

c. Undergone treatment or counseling by a psychologist or psychiatrist? c. Yes _____ No ____

d. Used, or are now using, cocaine, barbiturates, amphetamines, marijuana, or other hallucinatory drugs, heroin, opiates, or other narcotics except as prescribed by a doctor? d. Yes _____ No ____

e. Undergone treatment or counseling for alcoholism, or advised to do so by a physician? e. Yes _____ No ____

Treatment: ______________________________________ Length of time since recovery: _________________

f. Applied for or received disability income benefits or pension benefits on account of sickness or injury? f. Yes _____ No ____

g. Had life, disability, or health insurance declined, postponed, changed, rated-up, cancelled, or withdrawn? g. Yes _____ No ____

h. Been diagnosed as having, or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? h. Yes _____ No ____

i. Do you smoke or use any tobacco products? i. Yes _____ No ____

Which Product?____________________________________ Amount per day: ______________________________

Continue to Page 3.

Section 2: Employee's Five Year Medical History (Continued)

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

		Y	N			Y	N
a.	Heart or chest pain	____	____	m.	Goiter or glands	____	____
b.	High blood pressure	____	____	n.	Kidneys	____	____
c.	Abnormal pulse	____	____	o.	Liver or gallstones	____	____
d.	Cholesterol	____	____	p.	Anemia, blood disease or disorder	____	____
e.	Diabetes	____	____	q.	Back or spinal disorder	____	____
f.	Cancer or tumors	____	____	r.	Neuritis or sciatica	____	____
g.	Lungs	____	____	s.	Nervous or mental disorder	____	____
h.	Ulcers or stomach disorder	____	____	t.	Epilepsy	____	____
i.	Chronic diarrhea or intestines	____	____	u.	Pleurisy or asthma	____	____
k.	Urinary system	____	____	w.	Genital disorder	____	____

3) Do you currently have any disorder, disease, or defect not shown above? Yes ___ No ___

List: ____

4) Are you currently taking medication prescribed or provided by a medical or other practitioner? Yes ___ No ___

List: ____

5) Are you currently pregnant? N/A _____ Yes ___ No ___

Expected date of delivery: ______________________________

6) What are the full details of all "Yes" answers to the questions above or on Page 2?
Attach additional pages if needed.

Question # and letter	Specify illness or condition. Detail 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 3: Eligible Dependent Information (Complete ONLY if applying for Dependent Insurance)

Complete for **all** Eligible Dependents applying for coverage.

Eligible Dependent's Name	Relationship	Gender	Age	Date Of Birth	Place of Birth	Height	Weight

Section 4: Eligible Dependent's Five Year Medical History (if applying for Dependent Insurance)

Please have your Eligible Dependent complete Section 4. Medical History is not required for children.

Name of Eligible Dependent: ____

1) Have you during the last **five** years: **(Check Yes or No)**

Please provide full details of all "Yes" answers under (6) on Page 5.

a. Undergone surgery, or were advised to have surgery and have done so? a. Yes _____ No _____

Reason: ____

b. Been admitted to a hospital, sanitarium, or other institution for observation, rest, diagnosis, or treatment? b. Yes _____ No _____

Reason: ____

c. Undergone treatment or counseling by a psychologist or psychiatrist? c. Yes _____ No _____

d. Used, or are now using, cocaine, barbiturates, amphetamines, marijuana, or other hallucinatory drugs, heroin, opiates, or other narcotics except as prescribed by a doctor? d. Yes _____ No _____

e. Undergone treatment or counseling for alcoholism, or advised to do so by a physician? e. Yes _____ No _____

Treatment: ______________________ Length of time since recovery: ______________

f. Applied for or received disability income benefits or pension benefits on account of sickness or injury? f. Yes _____ No _____

g. Had life, disability, or health insurance declined, postponed, changed, rated-up, cancelled, or withdrawn? g. Yes _____ No _____

h. Been diagnosed as having, or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? h. Yes _____ No _____

i. Do you smoke or use any tobacco products? i. Yes _____ No _____

Which Product? ______________________ Amount per day: ______________________

Continue to Page 5.

Section 4: Eligible Dependent's Five Year Medical History (Continued)

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

		Y	N			Y	N
a.	Heart or chest pain	____	____	m.	Goiter or glands	____	____
b.	High blood pressure	____	____	n.	Kidneys	____	____
c.	Abnormal pulse	____	____	o.	Liver or gallstones	____	____
d.	Cholesterol	____	____	p.	Anemia, blood disease or disorder	____	____
e.	Diabetes	____	____	q.	Back or spinal disorder	____	____
f.	Cancer or tumors	____	____	r.	Neuritis or sciatica	____	____
g.	Lungs	____	____	s.	Nervous or mental disorder	____	____
h.	Ulcers or stomach disorder	____	____	t.	Epilepsy	____	____
i.	Chronic diarrhea or intestines	____	____	u.	Pleurisy or asthma	____	____
k.	Urinary system	____	____	w.	Genital disorder	____	____

3) Do you currently have any disorder, disease, or defect not shown above? Yes ___ No ___

List: ____

4) Are you currently taking medication prescribed or provided by a medical or other practitioner? Yes ___ No ___

List: ____

5) Are you currently pregnant? N/A _____ Yes ___ No ___

Expected date of delivery: ____

6) What are the full details of all "Yes" answers to the questions above or on Page 4?
Attach additional pages if needed.

Question # and letter	Specify illness or condition. Detail 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

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 Eligible Dependent (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, pharmacy benefit manager, consumer reporting agency, the MIB, Inc. ("MIB") or other health care provider that has provided treatment or services to me ("my Providers") to disclose my entire medical record and pharmaceutical record to Pacific Guardian Life Insurance Company Limited (the "Company"), its employees, authorized agents and representatives, and any insurance support organization acting on the Company's behalf for the purpose of evaluating my application for insurance. 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 MIB, any consumer reporting agency, or other insurance support organization or employer having information or records relative to 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 my Providers to release and disclose my entire medical record without restriction to the Company.

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 for 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. I have reviewed the Notice of Insurance Information Practices that is included in my application for insurance and I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB.

This authorization will be valid for 30 months following the date of my signature below. A copy of this authorization is as valid as the original. I understand that I may revoke this authorization at any time by giving written notice to the Company at 1440 Kapiolani Boulevard, Suite 1700; Honolulu, HI 96814, Attention: Group Department. I understand that a revocation is not effective to the extent that any of My Providers have 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 also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected 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 Eligible Dependent (if applicable) Date

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

Medical Information Notice (Retain for your records.)

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 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:

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Suite 400
Braintree, MA 02184-8734
infoline@mib.com