



PERSONAL HEALTH INFORMATION

Thank you for choosing AlwaysCare Benefits, Inc. (a Starmount Life Insurance Company) and National Guardian Life Insurance Company. All sections of this form must be completed and received by AlwaysCare within 30 days of the signature date.

Employers: Please completely fill out Section 1 and Section 2 on this page and forward the entire form to the employee. Refer to your Policy and employee records for this information. These records are your property and are not on file with National Guardian Life or AlwaysCare. An incomplete form will result in a delay in processing your employee's request for insurance.

Section 1 - Employer Details (to be completed by Employer) PLEASE PRINT CLEARLY
Employer Name: Policy Number:
Division (if applicable):
Employer Mailing Address (Street, City, State, Zip Code):
Benefits Contact Name: (First, Last)
Benefits Contact Email Address: Benefits Contact Phone: () -

Section 2 - Applicant Details (to be completed by Employer) PLEASE PRINT CLEARLY
Employee Name: (First, MI, Last)
Base Annual Earnings*: Social Security Number: - - Date of Hire (mm/dd/yyyy): / /

* Base annual earnings as described in the contract with National Guardian Life Insurance Company.

Coverage Details

- Check the box(es) next to each row of the applicant's existing or new employer-sponsored coverage.
Enter the amount of any existing coverage (including Guarantee Issue*) in Current Coverage. Please include the amount of Employee Basic Life coverage even if the applicant is not requesting Basic Life coverage at this time.
Enter the amount of Additional Coverage Requested by the applicant that requires Medical Underwriting.
If the applicant is enrolling after his/her initial eligibility, check Late Entrant as the Reason for Medical Underwriting, if not, check Other as the reason.

Table with 4 columns: Reason for Medical Underwriting, Current Coverage, Additional Coverage Requested. Rows include Life Insurance Coverage (Employee Basic Life, Employee Supplemental or Voluntary Life, Spouse Basic Life, Spouse Supplemental or Voluntary Life) and Disability Insurance Coverage (Short-Term Disability, Long Term Disability).

* Guarantee Issue is the maximum amount of coverage - as defined in the contract with National Guardian Life Insurance Company - that does not require an applicant to provide proof of good health.

Is the employee requesting more than \$15,000 of coverage for a child? Yes No Number of Children: Amount Requested Per Child: \$

Employees: Please complete pages two and three. It should take you about 7 to 10 minutes to complete this form

Employee: First Name _____ Last Name _____

Employee Section

Please answer all questions on this page completely and accurately and certify your answers on the next page. **Leaving information blank will result in delays and may result in your file being closed.** AlwaysCare may contact you for additional or missing information.

Section 3 – Employee Information (Complete even if employee is <u>not</u> applying for coverage)				PLEASE PRINT CLEARLY	
Home Mailing Address (Street, Apt. #):			City:		
State:	Zip Code:	Employer:			
Daytime Phone: ()		Evening Phone: ()		Height: ___Ft. ___In.	Weight _____ lbs.
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: / /	Email Address:			

Section 4 –Spouse or Eligible Partner Information (Complete <u>only</u> if applying for this coverage)				PLEASE PRINT CLEARLY	
First Name:		Last Name:		Social Security Number - -	
Daytime Phone: ()		Evening Phone: ()		Height: ___Ft. ___In.	Weight _____ lbs.
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth: / /	Email Address:			

Section 5 – Medical Information (to be completed only by applicants requesting coverage)

If you or anyone proposed for coverage can answer Yes to any of Questions 1 – 6 below, check the appropriate box and provide **additional details in Section 6. Residents of Florida, Maine, Minnesota, North Carolina, Vermont or Wisconsin, please review the condition specific wording required by your state on page 4 of this form prior to answering these questions.**

1. Within the past 5 years, with the exception of a past pregnancy, have you lost time from work for more than 10 work days for the same physical, mental, or emotional condition, disability, injury, or sickness?	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse
2. Within the past 2 years, have you used any controlled substances, with the exception of those prescribed by your physician, received medical advice or sought treatment for drug or alcohol abuse, or been charged with operating a motor vehicle under the influence of drugs or alcohol?	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse
3. Are you currently undergoing any diagnostic testing for symptoms without a final diagnosis or resolution?	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse
4. Are you currently pregnant? _____ If yes, what was your pre-pregnancy weight? _____ lbs	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse
5. During the past 5 years have you been diagnosed with or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any other immune deficiency disorder?	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse

6. During the past 5 years have you been diagnosed with, treated for, treated with, or had any symptoms due to any of the following conditions or treatments listed below?

	Employee	Spouse		Employee	Spouse
Heart Related Surgery or Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Failure/Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease (excluding high blood pressure & heart murmur)	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (excluding Hepatitis A)	<input type="checkbox"/>	<input type="checkbox"/>
Blocked Arteries (including arteriosclerosis, atherosclerosis, aneurysms, or deep vein blood clots)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Obstructive Pulmonary Disorder (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	Knee Disorder, Injury, or Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Back or Neck Disorder, Injury, or Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Adjustment Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Joint/Ligament Disorder, Injury, or Surgery	<input type="checkbox"/>	<input type="checkbox"/>
Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis or Osteopenia	<input type="checkbox"/>	<input type="checkbox"/>
Depression (single episode)	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis (MS)	<input type="checkbox"/>	<input type="checkbox"/>
Depression (multiple episodes)	<input type="checkbox"/>	<input type="checkbox"/>	Amyotrophic Lateral Sclerosis (ALS)	<input type="checkbox"/>	<input type="checkbox"/>
Psychotic/Personality Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>
Other Mental/Nervous/Psychiatric Disorders (including Anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (excluding Basal Cell Carcinoma)	<input type="checkbox"/>	<input type="checkbox"/>	Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>
Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>

Employee First Name _____

Last Name: _____

Section 6 – Additional Details: If you or anyone proposed for coverage checked any box next to Questions 1 – 6, please provide details in the space below. If you need more space, please attach, sign and date an additional sheet.

Question # or Condition	Applicant Name	Medications/ Treatment	Date of Diagnosis	Date of Last Symptom	Current Status of Condition	Physician's Name and Phone #

Section 7 – Certification Statement *(To be completed by all applicants)*

By checking this box: Employee Spouse

I hereby certify that I have reviewed each of the above questions and conditions.
I also certify that I have checked all of the questions and conditions that apply to my health history.

Section 8 – Fraud Statement *(To be completed by all applicants)*

I hereby certify that the above statement and answers are complete and true to be the best of my knowledge and belief concerning the past and present state of health and medical history of the persons to whom the statement and answers relate. I agree that this document and all its contents shall form a part of my enrollment request for group benefits. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

This information may be used by AlwaysCare (for fully insured coverages) or my employer/administrator (for self-funded coverages) for plan administration purposes to decide if the person(s) is/are eligible for coverage. I acknowledge that I have read the disclosure notice on the last page of this application.

Notice: *Anyone applying for coverage is required to notify National Guardian Life and AlwaysCare in writing at the address below of any changes in their medical condition to the best of their knowledge between the date you sign this form and the date the coverage is approved.*

Employee's Signature
or Legal Representative/ Relationship to
Employee **(Required)**

____/____/____
Date Signed

Spouse's (or Eligible Partner's) Signature
or Legal Representative/Relationship to Spouse
(Required only if applying for coverage)

____/____/____
Date Signed

Please return the completed Employer and Employee sections to:

National Guardian Life Insurance Company
c/o AlwaysCare Benefits, Inc.
P.O. 98100
Baton Rouge, LA 70898-9100

If you have any questions or concerns about this form, please call AlwaysCare's Customer Service Department toll-free at 888-729-5433, Ext. 2013, Monday through Friday, 7:30 a.m. – 8:30 p.m. (CST), Saturday, 9:00 a.m. – 3:00 p.m. (CST).

State Specific Information

Please Do Not Return This Page – Retain for Your Records

FOR RESIDENTS OF CALIFORNIA: FOR YOUR PROTECTION, CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects a person to criminal and civil penalties.

Florida residents: AIDS/HIV Condition: Has anyone proposed for coverage ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection or had unexplained weight loss or enlarged lymph nodes?

Maine residents: You are not required to disclose whether you have been tested for HIV, if you have not developed symptoms of the disease AIDS or ARC, in your answer to any of the following questions.

Minnesota residents: YOU NEED NOT DISCLOSE AN HIV (AIDS VIRUS) TEST WHICH WAS ADMINISTERED: (1) TO A CRIMINAL OFFENDER OR CRIMINAL VICTIM AS A RESULT OF A CRIME THAT WAS REPORTED TO THE POLICE; (2) TO A PATIENT WHO RECEIVED THE SERVICES OF EMERGENCY MEDICAL SERVICES PERSONNEL AT A HOSPITAL OR MEDICAL CARE FACILITY; (3) TO EMERGENCY MEDICAL PERSONNEL WHO WERE TESTED AS A RESULT OF PERFORMING EMERGENCY MEDICAL SERVICES.

North Carolina residents: AIDS/HIV Condition: Has anyone proposed for coverage ever been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or any other immune deficiency disorder? "AIDS Related Complex (ARC)" is a condition with signs and symptoms which may include generalized lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause. "Disorder of the Immune System" includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia), of white blood cell production and maturation, and the immune-deficiency disorders both congenital and acquired. Also included in disorders of immunity are lupus erythematosis, Grave's Disease, rheumatoid arthritis, primary biliary cirrhosis, and others.

Vermont residents: AIDS/HIV Condition: Has anyone been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) by a licensed medical physician?

Wisconsin residents: AIDS/HIV Condition: Had any lab tests, x-ray, electrocardiogram, or other diagnostic testing other than HIV testing or those requested as part of routine physical with normal findings?

Disclosure Notice
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I authorize AlwaysCare Benefits (a Starmount Life Insurance company) and National Guardian Life Insurance Company to release information in its file to the Medical Information Bureau, Inc., and other insurance companies to whom I or my children may apply for Life or Health Insurance, or other persons or organization, performing business or legal services in connection with this application or a claim, or as may be otherwise lawfully required. Except as specified, this information will not be given, sold, or transferred to any person without first obtaining my consent or a written form stating the use and need for such information.

I understand that upon written request, I am entitled to receive details of the procedures I must use to implement my right to access, correct and amend any personal information collected about myself or my children in connection with this application.

I understand that if I request details about any medical record information collected about myself in connection with this application, the medical record information and the identity of the medical care institution, or medical professional that provided the information, shall be supplied only to a licensed medical professional designated by me, unless otherwise authorized by the medical professional or institution who provided such information.

I understand that misstatements, misrepresentations, or omissions in my response to the request for information above may result in the voiding of coverage.

Summary of information: In order to properly underwrite your request for group benefits, AlwaysCare and National Guardian Life must collect certain information about your physical condition. You are the most important source of information about your own health, and to the degree it is possible, We will rely on only information obtained from you. If We do find We are required to contact a medical professional or institution, We may contact them directly using the authorization on the application form.

Information We collect about you will not be given to anyone without your consent, except when it is necessary for conducting our business. The only people that have access to the information are employees who service your benefits or claims and those who have a regulatory or legal need for the information. In other situations, We will ask you for written authorization to disclose information about you.

In most cases the only information We will collect is provided by you. You are encouraged to keep a copy of this form for your records. If We find it necessary to contact medical providers or institutions, there are procedures by which you can obtain access to the personal information about you which We have collected. Upon written request, We will provide you with information in your file. Medical information will be disclosed only through a physician you designate, unless otherwise authorized by the medical professional or institution who provided such information to Us. Details regarding your right to correct or amend information in your file will be furnished upon written request. If you have any further questions about these policies and practices, please write to: AlwaysCare Benefits, Inc., Privacy Officer, P.O. Box 98100, Baton Rouge, LA 70898-9100.

All policies are underwritten by National Guardian Life Insurance Company*.

*National Guardian Life Insurance Company is not affiliated with The Guardian Life Insurance Company of America, a.k.a. The Guardian or Guardian Life.