



P.O. Box 14319
Lexington KY 40512

Please complete this form in ink. Erasures and changes invalidate this form.

Planholder Name (Company Name)		Group Plan No.
Complete the following information for each person to be underwritten:		
Name (Last, First, Middle Initial)		
Employee:		
Spouse		
Child		
Child		
<p>The following information was omitted from the Evidence Of Insurability Form EOI2012. Please provide responses to the following questions. All questions should be answered by each person applying for coverage. However, if applying for coverage for a child, the Employee must complete questions for the child applying for coverage.</p> <p>Complete the following question if you are enrolling for Cancer coverage. NOTE: Additional information may be required.</p> <p>Has anyone to be covered been treated for or diagnosed as having Cancer in any form, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) within the last 5 years?</p> <p><input type="checkbox"/> Yes, I have. <input type="checkbox"/> No, I haven't. <input type="checkbox"/> Yes, my spouse has. <input type="checkbox"/> No, my spouse hasn't.</p> <p><input type="checkbox"/> Yes, my dependent child(ren) have. <input type="checkbox"/> No, my child(ren) haven't.</p>		

Please retain a copy for your records and submit this form to Guardian

Representations of the Proposed Insured(s) Please read and sign below.

Those parties who sign below hereby represent that the statements and answers to the question(s) are, to the best of the knowledge and belief of the party signing below, full, complete, true and correctly recorded. Those parties who sign below understand that they will form the basis of any coverage under the Group Plan for which Evidence of Insurability is required. When used in this Part , "I" refers to the person applying for insurance signing below.

Also, it is mutually understood and agreed that (1) the Company reserves the right to request, at its expense (except in the case of a late entrant, it is not at the Company's expense), that any proposed insured be examined by an accredited medical examiner selected by the Company; (2) no Group Insurance will be binding or in force until satisfactory evidence of insurability is submitted, approved by the Company and the required premiums are received by the Company; and: (a) I am actively at work on a full-time basis (as defined in the Group Plan) for full pay on the date my Group Insurance becomes effective; otherwise, (b) I become insured on the date I do return to work and satisfy a waiting period (as defined in the Group Plan) of full-time service ; (3) coverage for my dependents will not take effect if a dependent other than a newborn is: (a) confined to the hospital or other health care facility; or (b) is unable to perform the normal activities of someone of like age and sex (4) no person, except the President, a Vice President or a Secretary of the Company, has authority to: (a) determine whether any contract(s) of insurance shall be issued on the basis of the application; (b) waive or modify any of the provisions of the application or any of the Company's requirements; (c) bind the Company by any statement or promise pertaining to any insurance contract(s) issued or to be issued on the basis of the application; or (d) accept any information or representation not contained in the written application; (5) the employer is hereby named the Proposed Insured's representative for the purpose of receiving premiums and remitting them to the Company. In the event the Company receives premiums in excess of the appropriate amount for the coverage provided, the Company will only be liable for the overpaid premiums plus applicable interest.

Any misrepresentation or omission, if found to be material, may adversely affect acceptance of the risk, claims payment or may lead to rescission of any coverage issued based on this Evidence of Insurability Form.

By my signature below, I agree with all of the terms, conditions, statements, and representations stated above in Representations of the Proposed Insured.

Signature of Employee

Date

Signature of Spouse

Date

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