Guardian Group
Guardian Life of The Caribbean Limited

Deductible Option:	
$250	X
$500	☐
$1,000	☐

HEALTH APPLICATION CONVERSION FORM GROUP

SS ID No. _____ **Group No: 3815**

Name of Group: GOVERNMENT OF ANGUILLA		
Name of Employee:		
Email Address:	**Telephone No:**	
Status: ☐ **Single** ☐ **Family**	**Date of Birth:** / / MM/DD/YY	**Sex:** ☐ **Male** ☐ **Female**
Mailing Address:		
Occupation:		
Are you or your dependant covered by any other medical plan? If yes →	**Name of Plan:**	**Name of Insurance Company:**
I hereby apply for health coverage under the Smart Choice Group Health Plan and confirm that I am familiar with the terms and conditions of the Plan and agree to be bound thereby.		
Effective Date of coverage: 01 / 01 /2020 MM/DD/YY	**Date entered employment/membership:** / / MM/DD/YY	

EMPLOYEE'S DEPENDENTS TO BE COVERED

Name of Dependent	Relationship	Date of Birth MM/DD/YY	Effective Date of Coverage	Termination Date

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION IN CONNECTION WITH ELIGIBILITY FOR GROUP INSURANCE

To all Re-insurers at Guardian Life of the Caribbean Limited medical or dental services or supplies and their representatives, the Medical Information Bureau, Inc., or other organisation, or an insurers medical or hospital service plans, prepaid health plans, employers, group policyholders/contractholders. For purposes of determining eligibility for insurance, and eligibility for benefits under an existing policy, I authorize you to furnish Alliance Insurance Services Limited and its reinsurers or its representatives performing business or legal functions, any information available about the medical history, condition, and treatment for myself, or the Dependants named in this Application.

I authorize Re-insurers of Guardian Life of the Caribbean Limited and Alliance Insurance Services Limited to use such information and to redisclose it for the above purposes to its representatives, the Medical Information Bureau, Inc., or other organisation, my employer, union, group contract holder and their representatives, any insurer, medical or hospital service plan, prepaid health plan, or reinsurer. I also authorize Alliance Insurance Services Limited to redisclose such information to any attending physician for treatment purposes, and when necessary to inform the employee of the reason insurance was declined to governmental authorities when necessary to prevent or prosecute fraud or other illegal activities, to any person who has an authorisation specifically permitting the redisclosure and as may be permitted or required by law. I agree that this authorisation is valid from the date below and a photocopy shall be as valid as the original. I know that I have a right to ask for and receive a copy of this authorisation.

Employee's Signature:_____ **Date:_____**

Administrator: _____ **Date:_____**