Guardian®

The Guardian Life Insurance Company of America
10 Hudson Yards
New York, NY 10001

MEDICAL REPORT FOR JUVENILE INSURANCE

1. Name of Child to be Insured	2. Date of Birth Month Day Year	3. Sex Male ☐ Female ☐
4. Are there any marks of identification?	5. How long have you known: A. The child? B. The Parents or Guardian	
6. After examining the child carefully, do you find any indication of past or present injury, disease or abnormality?	7. Does the child appear to be well nourished and in good health?	
8. Do the home surroundings and general environment appear to present any abnormal hazard to the life or health of the child?	9. Remarks:	
This examination was made at the child's home ☐, my office ☐, At _____ A.M. _____ P.M. On: Date _____ , _____ Examination was made at request of _____ Agency	Signature _____ M.D. Address _____	

Check One:
☐ **The Guardian Life Insurance Company of America**
☐ **The Guardian Insurance & Annuity Company, Inc.**

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INSTRUCTIONS TO EXAMINER

1. Please complete the fee voucher at the bottom of this form. Do not detach. This will serve as your bill to the Company. Payment will be made from the Home Office for reasonable and customary fees.

2. At the request of our local agency, the examination may be mailed to the agency, attention: NEW BUSINESS CLERK. In the absence of such request, all material should be mailed to the Home Office. In no case is this information to be given to the agent. Information which you regard as especially confidential may be reported directly to the Company's Medical Director at the Home Office by separate letter.

M172-8/99

DO NOT DETACH **Please complete EXAMINER'S FEE VOUCHER fully to insure prompt payment. (JUVENILE M 172)**

Proposed Insured's Name (Please Print)	Date of Birth	Agent's/Dealer's Name	Agency

Examination Fee	Authorized ECG	Special Tests--X-Ray	Other (Specify)	Total Fee
$	$	$	$	$

Name of Doctor or Paramedical Facility

Street and Number

City State Zip Code

IMPORTANT
IRS NUMBER MUST BE PROVIDED FOR PAYMENT:
IRS OR EMPLOYER ID NUMBER:

_____

HOME OFFICE USE ONLY

Policy Number	Amount	Underwriter & Date	Life:	Health:	Group ( ) ☐
			H.O. (140100) ☐	H.O. (210100) ☐	Dept. # _____
			NRO (140402) ☐	NRO (210102) ☐	Other ( )
			WRO(140304) ☐	WRO(210104) ☐	Dept. # _____ ☐