Reset Form Button:

GROUP INSURANCE ENROLLMENT FORM

Group Policy No.	Certificate No.	Occupation:	Male ☐ Female ☐	Mr. ☐ Mrs. ☐ Ms. ☐

Last Name | First Name | Middle Name

Address:

Telephone No: Home: Work: Cell:	**E-mail Address**:	Date of Birth: Day / Month / Year	Coverage: ☐ Life ☐ Health

Marital Status: ☐ Single ☐ Divorced ☐ Married Maiden Name________________________ ☐ Separated ☐ Widow(er) ☐ Common Law	Do you wish to cover your dependants? ☐ Yes ☐ No	No. of dependants including spouse:

BENEFICIARY DESIGNATION

Name of Beneficiary: | Relationship to Employee:

Date of Birth: | National Registration/Driver's Licence/Passport No: | Nationality:

Name of Beneficiary: | Relationship to Employee

Date of Birth: | National Registration/Driver's Licence/Passport No: | Nationality:

I reserve the right to change the beneficiary designated above, subject to any statutory requirement. I authorise my employer to deduct them from my pay such contributions to premium as are required to be made by me in respect of coverage under the Group Policy.

EMPLOYMENT HISTORY ***EMPLOYER TO COMPLETE ALL ITEMS IN THIS SECTION THOROUGHLY***

Date Employed	Day / Month / Year	EARNINGS ☐ Weekly ☐ Monthly ☐ Annually Salary ________________________	This employee has been continuously employed since the stated date of employment and is currently working on a full-time basis for a minimum of 30 hours each week. ________________________________ Employer's Stamp & Administrator's Signature
Date Appointed	Day / Month / Year		
End of Waiting Period	Day / Month / Year		
Effective Date of Insurance	Day / Month / Year		

DEPENDANTS TO BE INSURED

1 = Spouse **2 = Common Law Spouse** **3 = Son** **4 = Daughter** **5 = Stepson** **6 = Stepdaughter**

Name	Date of Birth	Relationship	Address
	Day / Month / Year		
	Day / Month / Year		
	Day / Month / Year		
	Day / Month / Year		

CONSENT TO RELEASE OF MEDICAL INFORMATION

I authorise any licensed physician, medical practitioner, hospital, clinic, medically related facility, insurance company, medical information bureau and any other organization, institution, or person that has any records or knowledge of my health, to release any such information to Sagicor Life Inc. ("Sagicor") and its Reinsurers.

DIRECT CREDIT AUTHORISATION

PLEASE COMPLETE ALL FIELDS BELOW

ACCOUNT INFORMATION

Name of Bank:	**Branch:**
Account Number to be Credited:	**Bank Transit Number:**

E-mail Address:

1. This authorisation revokes and replaces all previous direct credit authorisations and shall continue to be in force until such time as I shall have expressly revoked it by at least 10 days' written notice delivered to Sagicor at its office. Notification must be provided to Sagicor of any change in the account to be credited and a new Direct Credit Authorisation form submitted to Sagicor at least ten (10) days before the change becomes effective.
2. It is understood and agreed that Sagicor shall not be required to obtain and will not seek confirmation or verification of the account information provided by me from the Bank or any third party and shall not be liable for any loss resulting from the inaccuracy of the information provided or from failure to notify Sagicor of a change of account in the manner provided for herein.
3. Any delivery of this authorisation to the Bank shall constitute delivery by the undersigned.
4. Sagicor may in its absolute discretion terminate this arrangement with immediate effect by written notice sent to my last known address on record.

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Date	Signature of Employee (Please sign as recorded at Bank where authorising Direct Credit)	Signature of Witness

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Name of Witness