Sagicor

# GROUP INSURANCE INFORMATION CHANGE FORM

**Please complete in BLOCK LETTERS. Incomplete forms will not be processed.**

## Insured Information

**Full Name of Insured** *(Last Name First Name Middle Name(s))*

| **Name of Company** | **Sagicor ID Number** *(See CariCARE Card)* |
|---|---|
| | |

**Valid Government Identification Number** (*Please provide one form of identification*)

☐ National ID ☐ Passport ☐ Driver's License

| **Gender** | **Marital Status** | **Date of Birth** | | |
|---|---|---|---|---|
| | | Day | Month | Year |
| ☐ Male ☐ Female | ☐ Single ☐ Married ☐ Common Law<br>☐ Separated ☐ Divorced ☐ Widow(er) | | | |

**E-Mail Address**

**Telephone Numbers**

| *(Home)* | *(Work)* | *(Cell)* |
|---|---|---|
| | | |

## Please Indicate All Changes That Are Being Requested

| | | |
|---|---|---|
| 1. ☐ Change of Coverage | 3. ☐ Change of Address | 5. ☐ Change of Name |
| 2. ☐ Add / Remove Dependants | 4. ☐ Change of Beneficiary | |

## 1. CHANGE OF COVERAGE

**Please Indicate the Type Coverage Being Requested**

☐ Individual ☐ Employee and one dependant ☐ Family

## 2. ADD / REMOVE DEPENDANT FAMILY MEMBERS

**Please Indicate the Dependant Family Members to be Added or Removed**

| Name | Relationship† | Date of Birth *DD-MM-YYYY* | Gender | Student* | Change | Effective Date *DD-MM-YYYY* |
|---|---|---|---|---|---|---|
| | Spouse | | ☐ Male ☐ Female | X | ☐ Add ☐ Remove | |
| | Child | | ☐ Male ☐ Female | ☐ Yes ☐ No | ☐ Add ☐ Remove | |
| | Child | | ☐ Male ☐ Female | ☐ Yes ☐ No | ☐ Add ☐ Remove | |
| | Child | | ☐ Male ☐ Female | ☐ Yes ☐ No | ☐ Add ☐ Remove | |
| | Child | | ☐ Male ☐ Female | ☐ Yes ☐ No | ☐ Add ☐ Remove | |

* The definition of a student is a child who has attained the age 19 or is under age 25 who is a full-time student attending a recognised educational institution and who is unmarried and fully dependent on the employee.

† For each child added, please provide a copy of his/her birth certificate. If adding a spouse, please provide a copy of the marriage certificate or declaration of common-law marriage.

† If any child being added was adopted, please provide the date of adoption and a copy of the legal documentation. | Date of Adoption (DD-MM-YYY)

If removing a dependant, please provide a reason:

## 3. CHANGE OF ADDRESS

| Please Provide New Address |
|---|
| |
| |
| |

## 4. CHANGE OF BENEFICIARY

**BASIC GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT**

I hereby designate the below as a beneficiary under the certificate and revoke the appointment of any existing beneficiary. I reserve the right, without the consent of any listed beneficiary, to make further changes subject to any statutory restrictions.

| Name | Relationship | Date of Birth DD-MM-YYYY | % to be Allocated (total must equal 100%) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**BENEFICIARY WITNESS (***This is required if beneficiaries are listed***)**

| | |
|---|---|
| 1. Name: | Signature: |
| 2. Name: | Signature: |

## 5. NAME CHANGE OF EMPLOYEE OR DEPENDANT

| Please Provide New Name and Supporting Documentation | | |
|---|---|---|
| Last Name | First Name | Middle Name(s) |
| | | |

Reason: ☐ Marriage (Please attach copy of marriage certificate)
☐ Other (Please specify and attach supporting documents) _____

I hereby authorise my employer, the policyholder, to deduct such contributions to premium from my salary as are required to be made by me in respect of coverage under the group policy.

_____ _____
Signature of Insured Date

_____ _____
Name of Employer / Plan Administrator (*Block Letters*) Signature of Employer / Plan Administrator

Additional Information/Comments

| |
|---|
| |