



# Group Insurance Enrolment/Change Form

New Employee  Change

Group Policy No.	Certificate/Employee No.	Male <input type="checkbox"/>	Female <input type="checkbox"/>
------------------	--------------------------	-------------------------------	---------------------------------

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ Job Title \_\_\_\_\_

Telephone No:	Date of Birth	Marital Status:
Cell:	DD   MM   YYYY	<input type="checkbox"/> Single <input type="checkbox"/> Divorced
Work:		<input type="checkbox"/> Married <input type="checkbox"/> Separated
		<input type="checkbox"/> Widow(er) <input type="checkbox"/> Common Law

Do you wish to cover your Eligible Dependents?  Yes  No

Coverage:  Single  Emp. + 1  Family

**SPOUSE DETAILS**  Spouse  Common Law Spouse (living together for at least 2 years)

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

Gender:  Male  Female | Date of Birth DD \_\_\_\_ MM \_\_\_\_ YYYY \_\_\_\_

**CHILDREN DETAILS**

Name	Relationship	Date of Birth	Gender	Student*
		DD   MM   YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		DD   MM   YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		DD   MM   YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		DD   MM   YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No
		DD   MM   YYYY	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No

\* Definition of a student is a child age 19 or under age 23 who is a **full-time student attending a recognised educational institution and who is unmarried and fully dependent on the employee.**

**EMPLOYMENT INFORMATION**

Date Employed DD \_\_\_\_ MM \_\_\_\_ YYYY \_\_\_\_

**EARNINGS**  
 Annual  Monthly  Weekly

Date Confirmed DD \_\_\_\_ MM \_\_\_\_ YYYY \_\_\_\_

Effective Date of Insurance DD \_\_\_\_ MM \_\_\_\_ YYYY \_\_\_\_ Salary \_\_\_\_\_

## BASIC GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT

Employee's Primary Beneficiary(ies)	Relationship	Date of Birth	% (total must equal 100%)

I reserve the right to change the beneficiaries appointed above subject to any statutory reasons.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Witness to Beneficiaries appointed** – (Required if Beneficiaries are listed.)

Name of Witness \_\_\_\_\_ Signature of Witness \_\_\_\_\_

## ACCOUNT INFORMATION FOR DIRECT PAYMENT OF CLAIMS

Name of Bank/Financial Institution (the "Bank") \_\_\_\_\_ Branch where account was opened \_\_\_\_\_

Account Type:  Savings  Chequing Account number to be credited (the "Account") \_\_\_\_\_

Email Address \_\_\_\_\_

1. I, the undersigned Insured Account Holder, hereby authorise Sagicor Life Inc ("Sagicor") to credit my Account with all payments due to me in settlement of claims payable under the Policy. Amounts so credited shall constitute valid discharge of payment obligations to me under the Policy.
2. 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 offices. Any change in the account to be credited must be notified to Sagicor by filing a new Direct Credit Authorisation at least 10 days before the change is to become effective.
3. 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.
4. Any delivery of this authorisation to the Bank shall constitute delivery by the undersigned.
5. Sagicor may in its absolute discretion terminate this arrangement with immediate effect by written notice sent to my last known address on record.

Signature of Insured Account Holder as recorded at Bank \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Name of Witness \_\_\_\_\_

## CONFIRMATION OF EMPLOYMENT

This employee has been continuously employed by us since the date of his/her employment shown and is at present working a minimum of 30 hours each week.

\_\_\_\_\_  
Company Stamp & Administrator Signature

\_\_\_\_\_  
Date

## INTERNAL USE ONLY

Checked by \_\_\_\_\_ Date \_\_\_\_\_