



GROUP INSURANCE ENROLLMENT FORM



Group Policy No.	Certificate No.	Occupation:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Mr. <input type="checkbox"/>	Mrs. <input type="checkbox"/>	Ms. <input type="checkbox"/>
First Name		Middle Name		Last Name			
Address:							
Telephone No: Home: Work:		Date of Birth: Day Month Year		Coverage: <input type="checkbox"/> Life <input type="checkbox"/> Health		No. of Dependents including Spouse?	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married Maiden Name _____ <input type="checkbox"/> Separated <input type="checkbox"/> Widow (er) <input type="checkbox"/> Common Law			Do you wish to cover your Dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No		Beneficiary:		Relationship:
WITNESSES – (Required if Beneficiaries are listed)							
1. Name: _____			Signature _____				
2. Name: _____			Signature _____				

I reserve the right to change the beneficiary appointed above subject to any statutory reasons. If the Group Insurance Plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay.

_____ Date _____ Signature

TO BE COMPLETED BY EMPLOYER – SHOULD BE THOROUGHLY COMPLETED			
First Employed	Day Month Year	EARNINGS <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually Salary _____	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 per week for full pay. _____ Company Stamp & Administrator Signature
Date Appointed	Day Month Year		
End of Waiting Period	Day Month Year		
Effective Date of Insurance	Day Month Year		

DEPENDENTS 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			
		Day Month Year			
		Day Month Year			

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution, person or medical information bureau that has or may hereafter have any records or knowledge of me or my health, to give such information to **SAGICOR LIFE INC / SAGICOR CAPITAL LIFE INSURANCE COMPANY LIMITED** any such information.

..... Date Employee Witness