



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)			
<input type="checkbox"/> National ID <input type="checkbox"/> Passport <input type="checkbox"/> Driver's License			
Gender	Marital Status		Date of Birth
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Separated	<input type="checkbox"/> Married <input type="checkbox"/> Divorced	<input type="checkbox"/> Common Law <input type="checkbox"/> Widow(er)
			Day Month Year
E-Mail Address			
Telephone Numbers			
(Home)	(Work)	(Cell)	

Please Indicate All Changes That Are Being Requested		
1. <input type="checkbox"/> Change of Coverage	3. <input type="checkbox"/> Change of Address	5. <input type="checkbox"/> Change of Name
2. <input type="checkbox"/> Add / Remove Dependents	4. <input type="checkbox"/> Change of Beneficiary	

1. CHANGE OF COVERAGE

Please Indicate the Type Coverage Being Requested		
<input type="checkbox"/> Individual	<input type="checkbox"/> Employee and one dependant	<input type="checkbox"/> 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		<input type="checkbox"/> Male <input type="checkbox"/> Female	X	<input type="checkbox"/> Add <input type="checkbox"/> Remove	
	Child		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Remove	
	Child		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Remove	
	Child		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> Remove	
	Child		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Add <input type="checkbox"/> 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-YYYY)	
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