

Employee Benefits Division P.O. Box 439, Kingston Telephone: (867) 929-8920-9 Facsimile: (876) 929-4730

APPLICATION FOR GROUP INSURANCE CONTRACT

Name of Entity:	TRN#:				
Subject to the approval of this application, the Applicant hereby requests the following selection of benefits. The Applicant understands that all members participating in the Plan(s) must enroll for the Plan Benefits and options shown below.					
PLAN BENEFITS					
GROUP LIFE & INCOME PROTECTION	GROUP HEALTH INSURANCE				
[] GROUP LIFE [] SALARY MULTIPLE:x Annual Salary					
[] Flat Cover \$per employee [] Other					
[] A.D. & D [] EQUAL TO GROUP LIFE BENEFIT	[] DENTAL & OPTICAL [] Combined [] Uncombined				
[] OTHER:	Coverage Amount(s) \$				
[] INCOME PROTECTION	\$				
[] CREDITOR LIFE	[] OVERSEAS EMERGENCY MEDICAL SERVICE (OEMS)				
[] PERSONAL ACCIDENT	OTHER				
[] VOLUNTARY BENEFITS [] PARENTAL LIFE [] PARENTAL HEALTH [] SUPPLEMENTAL LIFE [] FAMILY LIFE [] CRITICAL ILLNESS [] SUPPLEMENTAL HEALTH [] DEPENDENT LIFE [] SUPPLEMENTAL DENTAL/OPTICAL	DESIRED EFFECTIVE DATE				
This also certifies that the Employer / Entity named above is a duly registered legal entity in Jamaica under the 'Companies Act' or the 'Registration of Business Names Act' or the 'Building Societies Act' or the 'The Co-operative Societies Act'.					
DESIGNATED BENEFIT MANAGER BENEFIT MANAGER'S EMAIL ADDRESS BENEFIT MANAGER'S MAIN PHONE #					
	AFFIX COMPANY STAMP				
SIGNATURE OF AUTHORIZED REPRESENTATIVE PRI	NT NAME DATE				
BROKER / AGENT'S STATEMENT					
I hereby certify that all of the information contained in this application is correct to the best of my knowledge and I know of nothing unfavourable about this firm or any individual proposed for insurance. I have complied with all of the underwriting rules and have explained the coverage fully to the applicant.					
AGENT: BRANCH/BROKET	R: AGENT'S NO.:				
Date Completed: Agent's Signature:					

DATA

1.	Name of E	ntity				
2.	Address	Address				
3.	Principal C	Officer:	Title:	Title:		
4.	Plan Admi	nistrator:	Title:			
5.	Type of Business: [] Sole Proprietorship		Partnership Company		[] Other	
6.	Nature of Business:					
7.	Type of In	dustry: [] Service [] Retail Trade [] Manufacturing or Wholesaling			[] Agriculture or Commerce ther	
0				Participation: Members	Dependents	
8.	(a)	Number of Full-time Employees/Total Members	hip		N/A	
	(b)	No. of Employees/Members with Eligible Depen	idents	N/A		
	(c) No. of Employees/Members enrolling				N/A	
	(d) No. of Employees/Members with Dependents en		nrolling	N/A		
	(e)	Will Employees/Members contribute to their Co	overage?	Yes	No	
	(f)	Will Employees/Members contribute to Depend	ent Coverage?	Yes	No	
9.	Entity's Pr	obation Period (Eligibility Period)				
10.	Name of S	Subsidiaries and/or Associated Entities:				
11.	Are the Er	nployees/Members of Entities given in (10) incl	uded in this proposal?	Yes	No	
12.	Are any classes of Employees/members (other than part-time Employees/Members) to be excluded from participation in your plan due to eligibility reasons? Yes No					
13.	Are any of	f your Employees/Members related by blood or	marriage?	Yes	No	
14.		coverage for which you are applying and descri ny other group insurance presently in force?	bed herein	Yes	No	
	If yes, please answer the following questions and include a copy of your in-force booklet or certificate and final premium billing statement:					
	1. Name of Insurance Company					
	2.	Type of Coverage				
	3.	Termination Date				
	4.	Number of Covered Employees/Members as of	Termination			
	5.	How long was prior coverage in force?				
15.	Have you, or any of your Employees/Members or their dependents incurred any claims in excess of \$50,000 during the past 12 months?YesNo				No	
16.		rerage for which you are applying in addition to surance presently in force?	any other	Yes	No	
If the answer to any of the above questions was 'Yes', explain under "Remarks" (Attach extra sheet if necessary).						
	REMARKS					
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