Sagicor

NEW EMPLOYEE ENROLMENT FORM

PLEASE COMPLETE ALL APPLICABLE INFORMATION IN BLOCK LETTERS

EMPLOYEE DATA

LAST NAME: _____

FIRST NAME:_____ MIDDLE NAME:_____

DATE OF BIRTH: SEX:

DD___MM___ YY_____ ☐ MALE ☐ FEMALE

HOME TEL.:_____

EMAIL: _____

ADDRESS:_____

_____

_____

MARITIAL STATUS: ☐ MARRIED ☐ SINGLE ☐ WIDOWED ☐ DIVORCED OR ☐ COMMON-LAW SEPARATED

BENEFICIARY'S NAME: _____

BENEFICIARY'S RELATIONSHIP: _____

BENEFICIARY'S DATE OF BIRTH: DD___ MM___ YY___

WITNESS:

_____

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

DATE: DD___MM___ YY____

SIGNATURE OF EMPLOYEE:_____

BACK OF ENROLMENT FORM

DO YOU WISH TO COVER YOUR DEPENDANTS ☐ YES ☐ NO

NAME	MALE	FEMALE	DATE OF BIRTH (D/M/Y)
SPOUSE			
CHILD			
CHILD			
CHILD			
CHILD			

Kindly attach and indicate the type of evidence for the following dependants.

☐ Common-Law Spouse (Common-Law Certificate)

☐ Student aged between 19-23 years (Student Certificate)

Group Policy No.
GT

Certificate No.

ADD. ☐ REIN. ☐

DATE EMPLOYED: DD___ MM___ YY____

DATE CONFIRMED: DD___ MM___ YY____

EFF. DATE OF INSURANCE: DD___ MM___ YY____

OCCUPATION: _____

Division: _____

Salary: ☐ W ☐ M ☐ A

Please state amount $_____

Insurance Class:

Life & Health ☐ Health ☐ Life ☐

This employee has been employed by this Company since the date of employment and is present working a minimum of 30 hours per week for full pay.

_____

Employer Signature & Stamp