Sagicor Life Inc

Sagicor Financial Centre,
16 Queen's Park West, Port of Spain, Trinidad
Tel: 628- 1636/ 7/ 8 Fax: 628- 1639

GROUP LIFE/HEATLH REPORTING FORM

Policy Holder ______________________

Plan # ______________ **Date** ____________

ADDITIONS *

NAME (Surname, First Name)	EFFECTIVE (Day / Month / Year)

NAME (Surname, First Name)	EFFECTIVE (Day / Month / Year)

The applicants listed as "Additions" have been continuously in our employ and are at present at work fro full time and fill pay.
*PLEASE ATTACH COMPLETED ENROLLMENT CARDS

TERMINATIONS

CERTIFICATE NUMBER	NAME (Surname, First Name)

REASON FOR TERMINATION	COVER (Single / Fam)	EFFECTIVE (Day / Month / Year)

CHANGE OF COVERAGE**

CERTIFICATE NUMBER	NAME (Surname, First Name)	EFFECTIVE (Day / Month / Year)

STATUS / SALARY / OTHER		REASON FOR CHANGE
CURRENT	NEW	

Status – Single/Family as applicable Salary – Please state Hourly/weekly/monthly/Annually as applicable
** PLEASE ATTACH COMPLETED CHANGE OF DEPENDENT COVERAGE CARDS

These charges will be reflected on the next billing once they are received by or before the 15th of the month.
Additions and Charges of Coverage cannot be processed without the completed cards

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Signature, Plan Administrator & Company Stamp

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Authorized Signature