GROUP INSURANCE ENROLLMENT FORM

Group Policy No.	Certificate No.	Occupation:	Male ☐ Female ☐	Mr. ☐ Mrs. ☐ Ms. ☐
First Name		Middle Name	Last Name	
Address:				

Telephone No: Home: Work:	Date of Birth: Day / Month / Year	Coverage: ☐ Life ☐ Health	No. of Dependents including Spouse?
Marital Status: ☐ Single ☐ Divorced ☐ Married Maiden Name________________________ ☐ Separated ☐ Widow (er) ☐ Common Law	Do you wish to cover your Dependents? ☐ Yes ☐ 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

		EARNINGS	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.
First Employed	Day / Month / Year	☐ Weekly	
Date Appointed	Day / Month / Year	☐ Monthly	
End of Waiting Period	Day / Month / Year	☐ Annually	
Effective Date of Insurance	Day / Month / Year	Salary ________________________	______________________________ Company Stamp & Administrator Signature

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**.

……………………………………… Date

……………………………………………. Employee

………………………………………………………………… Witness

GI40010 – February 2015