Sagicor

REPORTING FORM

Policyholder: _____

Policy Number: _____ Date: _____

CHANGES IN CLASSIFICATION/SALARY

Cert. #	Name	New Amounts of Insurance		* Dep. Ben.	Salary or New Insurance Code EE/EE+1/Fam	Day I Month I Year			REINSTATEMENTS				
		Life	A.D. & D.						Cert. #	Name	Date of Retirement Day I Month I Year		

* Indicate by "Y" if Dependent Benefits are being added and "N" if being cancelled

TERMINATIONS						ADDITIONS				
Cert. #	Name	State Reason for Termination	Date Employment Ceased Day I Month I Year			Month of Last Deduction	Name	Date Effective Day I Month I Year		

THIS FORM SHOULD BE COMPLETED IN DUPLICATE
RETAIN THE COPY FOR YOUR FILES

THE APPLICANTS LISTED AS "ADDITIONS" HAVE BEEN CONTINUOUSLY IN OUR EMPLOY FROM THE DATE EMPLOYED AND ARE AT PRESENT AT WORK FOR FULL-TIME AND FULL PAY.

_____ Policyholder

_____ Authorized Signature