CLEAR FORM

Sagicor

CARICARE HEROES GROUP LIFE RENEWAL FORM – TRINIDAD & TOBAGO

☐ MAINTAIN EXISTING COVERAGE ☐ CHANGE COVERAGE LEVEL ☐ ADD/REMOVE DEPENDENT ☐ BENEFICIARY CHANGE

SECTION A

Name of Association/Board/Company/Council/Entity:	Occupation:	Male ☐ Female ☐	Mr. ☐ Mrs. ☐ Ms. ☐

Last Name **First Name** **Middle Name**

Address:

Telephone No: (xxx)-(xxx)-(xxxx)	E-mail Address:	Date of Birth:
Home:		Day I Month I Year
Work:		
Cell:		

SECTION B

DEPENDANTS TO BE REMOVED **DEPENDENTS TO BE ADDED**

1 = Spouse **2 = Common Law Spouse** **3 = Son** **4 = Daughter** **5 = Stepson** **6 = Stepdaughter**

Name	Date of Birth	Relationship	Address
	Day I Month I Year		
	Day I Month I Year		
	Day I Month I Year		
	Day I Month I Year		

SECTION C

PLAN PARTICULARS- PLEASE PUT AN "X" BY YOUR CURRENT COVERAGE AND CLEARLY TICK THE NEW COVERAGE LEVEL

Under Age 65	Please tick 1, 2 , 3, 4OR 5	Life	AD&D	C.I.
Level 1 package	☐	100,000	100,000	50,000
Level 2 package	☐	150,000	150,000	75,000
Level 3 package	☐	250,000	250,000	100,000
Level 4 package	☐	500,000	500,000	150,000
Level 5 package	☐	1,000,000	1,000,000	300,000
Age 65 -75	**Please tick 1, 2 , 3,4 OR 5**	**Life**	**AD&D**	**C.I.**
Level 1 package	☐	50,000	50,000	25,000
Level 2 package	☐	75,000	75,000	37,500
Level 3 package	☐	125,000	125,000	50,000
Level 4 package	☐	250,000	250,000	75,000
Level 5 package	☐	500,000	500,000	150,000

SECTION D

BENEFICIARY DESIGNATION

Name of Beneficiary	Relationship to Employee	National ID# / Driver's License / Passport No.	Date of Birth:	% (100)

BENEFICIARY - Complete the section below. You will be the beneficiary for your spouse and child(ren) unless you specify otherwise.

Name of Dependent	Beneficiary	Relationship	Date of Birth:	% (100)

I reserve the right to change the beneficiary designated above, subject to any statutory requirement.

I authorise any licensed physician, medical practitioner, hospital, clinic, medically related facility, insurance company, medical information bureau and any other organization, institution, or person that has any records or knowledge of my health, to release any such information to Sagicor Life ("Sagicor") and its Reinsurers.

I will ensure to remit the amended / renewal premiums in based on my requested changes above effective February 1st 2022. I understand that Sagicor reserves the right to amend my benefits in accordance to premiums received thereafter.

.....	.....	.....
Date	**Signature of Employee/Member**	**Signature of Witness**
.....	.....	.....
Agent / Broker Name (PRINT)	**Agent / Broker No.**	**Name of Witness**