Sagicor

GROUP INSURANCE ENROLLMENT FORM

Sagicor CAPITAL LIFE

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

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

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 / SAGICOR CAPITAL LIFE INSURANCE COMPANY LIMITED** any such information.

…… Date …… Employee …… Witness