Group Insurance Enrolment/Change Form

Sagicor
Wise Financial Thinking for Life

New Employee ☐ Change ☐

Group Policy No.	Certificate/Employee No.	Male ☐ Female ☐	
First Name	Middle Name	Last Name	
Address		Job Title	
Telephone No: Cell: Work:	Date of Birth DD I MM I YYYY	Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Separated ☐ Widow(er) ☐ Common Law	

Do you wish to cover your Eligible Dependents? ☐ Yes ☐ No

Coverage: ☐ Single ☐ Emp. + 1 ☐ Family

SPOUSE DETAILS

☐ **Spouse** ☐ **Common Law Spouse (living together for at least 2 years)**

First Name Middle Name Last Name

Gender: ☐ Male ☐ Female Date of Birth DD ____ MM ____ YYYY ____

CHILDREN DETAILS

Name	Relationship	Date of Birth	Gender	Student*
		DD I MM I YYYY	☐ Male ☐ Female	☐ Yes ☐ No
		DD I MM I YYYY	☐ Male ☐ Female	☐ Yes ☐ No
		DD I MM I YYYY	☐ Male ☐ Female	☐ Yes ☐ No
		DD I MM I YYYY	☐ Male ☐ Female	☐ Yes ☐ No
		DD I MM I YYYY	☐ Male ☐ Female	☐ Yes ☐ No

* Definition of a student is a child age 19 or under age 23 who is a **full-time student attending a recognised educational institution and who is unmarried and fully dependent on the employee.**

EMPLOYMENT INFORMATION

Date Employed DD____ MM____ YYYY____

Date Confirmed DD____ MM____ YYYY____

Effective Date of Insurance DD____ MM____ YYYY____

EARNINGS

☐ Annual ☐ Monthly ☐ Weekly

Salary _____

BASIC GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT

Employee's Primary Beneficiary(ies)	Relationship	Date of Birth	% (total must equal 100%)

I reserve the right to change the beneficiaries appointed above subject to any statutory reasons.

Signature _____ Date _____

Witness to Beneficiaries appointed – (Required if Beneficiaries are listed.)

Name of Witness _____ Signature of Witness _____

ACCOUNT INFORMATION FOR DIRECT PAYMENT OF CLAIMS

Name of Bank/Financial Institution (the "Bank")

_____

Branch where account was opened

_____

Account Type: ☐ Savings ☐ Chequing

Account number to be credited (the "Account")

_____

Email Address _____

_____

1. I, the undersigned Insured Account Holder, hereby authorise Sagicor Life Inc ("Sagicor") to credit my Account with all payments due to me in settlement of claims payable under the Policy. Amounts so credited shall constitute valid discharge of payment obligations to me under the Policy.
2. This authorisation revokes and replaces all previous Direct Credit Authorisations and shall continue to be in force until such time as I shall have expressly revoked it by at least 10 days written notice delivered to Sagicor at its offices. Any change in the account to be credited must be notified to Sagicor by filing a new Direct Credit Authorisation at least 10 days before the change is to become effective.
3. It is understood and agreed that Sagicor shall not be required to obtain and will not seek confirmation or verification of the account information provided by me from the Bank or any third party and shall not be liable for any loss resulting from the inaccuracy of the information provided or from failure to notify Sagicor of a change of account in the manner provided for herein.
4. Any delivery of this authorisation to the Bank shall constitute delivery by the undersigned.
5. Sagicor may in its absolute discretion terminate this arrangement with immediate effect by written notice sent to my last known address on record.

Signature of Insured Account Holder as recorded at Bank

_____

Date

_____

Signature of Witness

_____

Name of Witness

_____

CONFIRMATION OF EMPLOYMENT

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 each week.

_____

Company Stamp & Administrator Signature

_____

Date

INTERNAL USE ONLY

Checked by

_____

Date

_____