Group Insurance Enrolment/Change Form

Sagicor
Wise Financial Thinking for Life

New Employee ☐ Changes: ☐ Name ☐ Beneficiary ☐ Add Dep. ☐ Remove Dep.

Group Policy No.	Certificate/Employee No.	Male	Female
GT2201174		☐	☐

First Name | Middle Name | Last Name

Address | Job Title

Telephone No:
Cell:
Home:

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

BASIC GROUP LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT

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

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.

ACCOUNT INFORMATION FOR DIRECT PAYMENT OF CLAIMS (continued)

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** _____

DEPENDENT DETAILS

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

EARNINGS ☐ Annual ☐ Monthly ☐ Weekly

Effective Date of Insurance DD____ MM____ YYYY____ Salary _____

Insurance Class: Life & Health ☐ Health only ☐ Life only ☐

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** _____