Sagicor

GROUP INSURANCE ENROLMENT FORM

Please complete in BLOCK LETTERS. Incomplete forms will not be processed.

1. GROUP INSURANCE INFORMATION

Group Name		
Group Policy Number	**Please Indicate Coverage Being Requested**	
	☐ Life & Health ☐ Health only ☐ Life only	☐ Individual ☐ Employee and one Dependant ☐ Family

2. APPLICANT INFORMATION

Full Name of Applicant *(Last Name First Name Middle Name(s))*				
Address				
Valid Government Identification Number (*Please provide one form of identification*)				
☐ National ID ☐ Passport ☐ Driver's License				
Gender	**Marital Status**			**Date of Birth**
☐ Male ☐ Female	☐ Single ☐ Married ☐ Common-Law ☐ Separated ☐ Divorced ☐ Widowed			Day / Month / Year
E-Mail Address				
Telephone Numbers				
(Home)	*(Work)*	*(Cell)*		

3. DEPENDANT DETAILS

Please Detail Below Any Dependant Family Members That You Wish to be Covered for Health Insurance

Name	Relationship†	Date of Birth DD-MM-YYYY	Gender	Student*	Address (If different to above)
	Spouse		☐ Male ☐ Female	X	
	Child		☐ Male ☐ Female	☐ Yes ☐ No	
	Child		☐ Male ☐ Female	☐ Yes ☐ No	
	Child		☐ Male ☐ Female	☐ Yes ☐ No	
	Child		☐ Male ☐ Female	☐ Yes ☐ No	

* The definition of a student is a child who has attained the age of 19 or is under age 25 who is a full-time student attending a recognised educational institution and who is unmarried and fully dependent on the employee.

† For each child added, please provide a copy of his/her birth certificate. If adding a spouse, please provide a copy of the marriage certificate or declaration of common-law marriage.

4. ACCOUNT INFORMATION FOR DIRECT PAYMENT OF CLAIMS

Name of Bank / Financial Institution *(the "Bank")*	**Branch of Account**
Name on Account *(If different to above)*	**Account Type**
	☐ Savings ☐ Chequing
Account Number to be Credited	**Transit Number**
E-Mail Address (If different to above)	

1. I, the undersigned Insured Account Holder, hereby authorise Sagicor Life Inc. / Sagicor Life (Eastern Caribbean) Inc. ("Sagicor") to use the account information provided above 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 due to me by Sagicor 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 office. I understand that 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.

5. BENEFICIARY DESIGNATION

Designate Beneficiaries for Basic Group Life and Accidental Death and Dismemberment				
I hereby designate the below as a beneficiary under the certificate. I reserve the right, without the consent of any listed beneficiary, to make further changes subject to any statutory restrictions.				
Name	Relationship	Date of Birth DD-MM-YYYY	Government ID	% to be Allocated (total must equal 100%)

6. EMPLOYMENT INFORMATION *(Employer to complete all items in this section)*

Employment Details			
Date Employed (DD-MM-YYYY)	Date Confirmed (DD-MM-YYYY)	End of Waiting Period (DD-MM-YYYY)	Effective Date of Insurance (DD-MM-YYYY)

Earnings	
☐ Weekly ☐ Monthly ☐ Annually	Basic Salary:

Confirmation of Employment	
This employee has been continuously employed by us since the stated date of confirmation and is currently working on a full-time basis for a minimum of 30 hours each week. Administrator Signature and Date:	Company Stamp:

Consent to Release of Medical Information

Sagicor Life Inc. / Sagicor Life (Eastern Caribbean) Inc. (the "Insurer") may require that it be supplied with health information held by persons and entities that have any record or knowledge of the Applicant's health ("Health Information"), which may include information resulting from medical examination of the Applicant at the Insurer's request. Your consent is needed to obtain Health Information. You do not have to give your permission but, where you do not, the Insurer will not be able to proceed with this application unless medical information is not required to process your application. Health Information may include details of the following:

- Your current state of health, any care, medication or treatment you are currently receiving and the results of referrals or tests you are waiting for.
- Your past health including details of any relevant illness, trauma, or referral for specialist advice or treatment, hospital admissions, consultations with any doctor, therapist or counsellor, including whether you have a history of any disorder of the joints or muscles; malignancy, degenerative (gradually worsening) diseases, heart disease, diabetes, depression, any mental disorder, drug or alcohol misuse or tobacco use.
- Details of any blood pressure readings, blood tests, biopsies, electrocardiograms (heart tests), height and weight, urinalyses (tests on urine), x-rays or other investigations.
- History of certain diseases among your immediate family.

I, the undersigned Applicant authorize any licensed physician, medical practitioner, hospital, clinic, medically related facility, insurance company, medical information bureau any other organisation, instruction, person or entity that has records or knowledge of my health to provide such information to the Insurer; its employees; authorized representatives; reinsurers and any person or organization engaged by the Insurer to perform administrative, legal or other professional services in connection with the Insurer's business; consent to automated decision-making where electronic underwriting applies to the level of coverage applied for; and agree to undergo electrocardiogram, x-ray, blood tests (for diabetes, AIDS, etc.) or any other tests considered necessary by the Insurer and/or its reinsurers. A copy of this consent shall be as valid as the original.

I hereby authorise my employer, the policyholder, to deduct such contributions to premium from my salary as are required to be made by me in respect of coverage under the group policy.

I understand that the completion and submission of this form does not represent automatic enrolment/guarantee eligibility for insurance coverage/benefits under the Policy and that my application may be subject to medical investigation/examination.

Signature of Insured _____ Date _____

Name of Witness (*Block Letters*) _____ Signature of Witness _____

Name of Employer / Plan Administrator (*Block Letters*) _____ Signature of Employer / Plan Administrator _____