Sagicor

PLEASE USE BLOCK LETTERS WHEN COMPLETING THIS FORM

GROUP CHANGE REQUEST FORM

PLEASE USE BLOCK LETTERS, TYPE OR PRINT WHEN COMPLETING THIS FORM

GROUP POLICY NO.	EMPLOYER
EMPLOYEE NO.	EMPLOYEE

CHANGE OF DEPENDENT STATUS (List Details Below):

Effective Date of Change:

☐ Application for Dependent Coverage ☐ Addition of Dependent (as listed below)

☐ Deletion of Dependent (as listed below) ☐ Cancel All Dependent Coverage

SURNAME	FIRST NAME	M.I.	RELATIONSHIP	DATE OF BIRTH

REASON FOR ADDITION OF DEPENDENT COVERAGE:
(Please attach supporting documents)

- ☐ MARRIAGE
- ☐ BIRTH OF CHILD
- ☐ TERMINATION OF DEPENDENT'S EMPLOYMENT
- ☐ OTHER (Specify)

REASON FOR DELETION OF DEPENDENT COVERAGE:

- ☐ DIVORCE/DEATH OF DEPENDENT
- ☐ DEPENDENT ATTAINED AGE 19 (OR 23, IF STUDENT)
- ☐ COMMENCEMENT OF DEPENDENT'S EMPLOYMENT
- ☐ OTHER (Specify)

I AGREE TO ANY CHANGE IN CONTRIBUTION NECESSITATED BY THE REQUESTED CHANGE IN COVERAGE

SIGNATURE OF WITNESS _____ DATE _____ SIGNATURE OF EMPLOYEE _____

APPOINTMENT/CHANGE OF BENEFICIARY:

I, _____,
(FIRST NAME) (M.I.) (LAST NAME)

DO HEREBY REVOKE ALL PREVIOUS APPOINTMENTS/DESIGNATIONS HERETOFORE MADE BY ME AND DO HEREBY DECLARE AND DIRECT THAT ALL PROCEEDS, PAYMENTS OR BENEFITS WHICH BECOME DUE ON OR AFTER MY DEATH IN ACCORDANCE WITH THE TERMS OF SAID GROUP POLICY SHALL BE PAID TO AND BE FOR THE BENEFIT OF:-

SURNAME	FIRST NAME	M.I.	RELATIONSHIP	% ALLOCATION

PLEASE NOTE: All Beneficiaries listed above are deemed to be revocable beneficiaries unless otherwise stated. If the beneficiary elected is less than 16 years of age, an adult must also be appointed as Trustee

SIGNATURE OF WITNESS _____ DATE _____ SIGNATURE OF EMPLOYEE _____

TO BE COMPLETED BY EMPLOYER:

ACKNOWLEDGEMENT OF REQUEST(S) FOR CHANGE IS NOTED:

AUTHORIZED OFFICER _____ DATE _____

CHANGE OF NAME:

PLEASE CHANGE THE NAME OF THE ☐ EMPLOYEE ☐ DEPENDENT

FROM: NAME CURRENTLY RECORDED ON FILE	
TO: SURNAME	
FIRST & MIDDLE NAMES	
REASON FOR NAME CHANGE: (Attach supporting documents)	☐ MARRIAGE ☐ OTHER (Specify)

CORRECTION OF DATE OF BIRTH:

(Attach supporting documents)

PLEASE CORRECT THE DATE OF BIRTH OF THE ☐ EMPLOYEE ☐ DEPENDENT

NAME OF EMPLOYEE/DEPENDENT:

CHANGE OF HEALTH CARE PROVIDER:

REQUESTED PROVIDER:

REASON FOR REQUESTING CHANGE: