Sagicor

MEMBER ENROLLMENT FORM

Employee No.

PLEASE USE BLOCK LETTERS WHEN COMPLETING THIS FORM

FOR EMPLOYER USE:	EMPLOYER/COMPANY NAME:											
POLICY No.		ACCOUNT No.		LOCATION:								
DATE HIRED:	Mth	Day	Year	EFFECTIVE DATE:	Mth	Day	Year	SALARY: $	PER: WK ☐	MTH ☐	ANN ☐	
REMARKS:												

EMPLOYEE INFO: **All fields in the Employee Info Section must be completed before processing can take place**

EMP. TRN

DATE OF BIRTH: Mth Day Year

SEX (M/F)

MARITAL STATUS (S/M/W/D):

BANK INFO:

BNS ☐ CITI ☐

FCIB ☐ FGB ☐

NCB ☐ RBTT ☐

Branch:

Account #:

Account Type:

Chequing ☐ Savings ☐

LAST NAME:

FIRST NAME:

MIDDLE INITIAL:

OCCUPATION:

CONTACT INFORMATION:

Address Line 1

Address Line 2

Telephone - Cell Phone - Other -

E-Mail Address

BENEFITS ELECTED:

LIFE	**AD&D**	**MED**	**HMO**	**DENTAL**	**OPTICAL**
Y N	Y N	☐ EE Only ☐ DEP (S)	☐ EE Only ☐ DEP (S)	☐ EE Only ☐ DEP (S)	☐ EE Only ☐ DEP (S)

DISABILITY INC.	**DEPENDENT LIFE**	**SUPPLEMENTAL LIFE**	**PARENTAL LIFE**	**CRITICAL ILLNESS**
Y N	$	$	$	$

SELECTED HMO CENTRE (Where applicable)**:**

I understand that all covered services with respect to the HMO Plan must be obtained through my selected HMO Centre.

DEPENDENTS:

LAST NAME:					
FIRST NAME:			TRN:		
MIDDLE INITIAL:	DATE OF BIRTH: Day Mth Year		SEX (M/F)	RELATION (S/C)	
LAST NAME:					
FIRST NAME:			TRN:		
MIDDLE INITIAL:	DATE OF BIRTH: Day Mth Year		SEX (M/F):	RELATION (S/C):	
LAST NAME:					
FIRST NAME:			TRN:		
MIDDLE INITIAL:	DATE OF BIRTH: Day Mth Year		SEX (M/F):	RELATION (S/C):	

BENEFICIARIES: **PLEASE NOTE:** All Beneficiaries listed below 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

LAST NAME:		FIRST NAME:	
MIDDLE INITIAL:	RELATIONSHIP:		% ALLOCATION:
TRUSTEE NAME:			
LAST NAME:		FIRST NAME:	
MIDDLE INITIAL:	RELATIONSHIP:		% ALLOCATION:
TRUSTEE NAME:			
LAST NAME:		FIRST NAME:	
MIDDLE INITIAL:	RELATIONSHIP:		% ALLOCATION:
TRUSTEE NAME:			

As provided under my Employer's Group Contract with Sagicor Life Jamaica Limited, I elect coverage as indicated above on behalf of myself and my eligible dependent(s) as listed above (where applicable) and authorize my employer to deduct from my earnings the contributions required (if any) for the benefits elected.

Having elected a Medical (including HMO), Dental and/or Optical Plan, I authorize Sagicor Life Jamaica Limited to have access to, and copies of, all medical, Hospital or other institution/agency records relating to the diagnosis, treatment or services provided to me or a covered dependent.

I hereby instruct my employer that, in the event of my death, all proceeds, payments or benefits which become due be paid to the person(s) named above under, "BENEFICIARY", and reserve for myself the sole right to change my instructions by informing my employer in writing.

I certify that the above information is correct to the best of my knowledge and confirm that I understand the conditions as stated above.
* I understand that the Effective Date of this insurance is subject to (a) my being actively at work on the day in question; (b) the rules and conditions of the company's underwriters as laid out in the Group Insurance Contract.

SIGNATURE OF EMPLOYEE: _____ DATE: _____

[*If employee is applying for coverage outside of eligibility period, please complete Health Statement on reverse*]

GROUP INSURANCE STATEMENT OF HEALTH

PART A – TO BE COMPLETED BY THE EMPLOYEE USING BLOCK LETTERS OR PRINT

IMPORTANT: **ALL QUESTIONS MUST BE ANSWERED USING 'YES', 'NO' OR 'N/A'**

EMPLOYER:	EMPLOYEE:
Group Policy Number:	Employee's Date of Birth:
Occupation:	Date Employed:
	Height: Weight:

Eligible Dependents (Spouse/Children)	Relationship to Employee	Height	Weight	Date of Birth

Place Tick [√] in Box ……..	Employee		Spouse		Children	
Have you or any of your dependents ever been diagnosed or treated for:	Yes	No	Yes	No	Yes	No
1. Any physical impairment?	☐	☐	☐	☐	☐	☐
2. Epilepsy, nervous breakdown, or any disorder of the brain or nervous system?	☐	☐	☐	☐	☐	☐
3. Tuberculosis or any disorder of the lungs, bronchial tubes, throat or respiratory system?	☐	☐	☐	☐	☐	☐
4. Allergies, hay fever or asthma?	☐	☐	☐	☐	☐	☐
5. Ulcer, colitis, or any disorder of the stomach, intestines, rectum, gall bladder or liver?	☐	☐	☐	☐	☐	☐
6. Hemorrhoids or rectal polyps or any disorder of the prostate?	☐	☐	☐	☐	☐	☐
7. Sugar or Albumin or blood in urine, or any disorder of the kidneys, urinary system, female or male organs, or breasts?	☐	☐	☐	☐	☐	☐
8. Diabetes, gout or any disorder of the thyroid or other glands?	☐	☐	☐	☐	☐	☐
9. Any disorder of the eyes, ears, skin, muscle, bones or joints?	☐	☐	☐	☐	☐	☐
10. Cancer, tumour, cyst or lump?	☐	☐	☐	☐	☐	☐
11. Any disorder of the blood, heart or circulatory system?	☐	☐	☐	☐	☐	☐
12. HIV, Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)?	☐	☐	☐	☐	☐	☐
13. Infertility, miscarriage or abortion?	☐	☐	☐	☐	☐	☐
13. Any disorder or injury involving the spine or skeletal system?	☐	☐	☐	☐	☐	☐
14. Arthritis, neuritis or rheumatism or any other connective tissue disorder?	☐	☐	☐	☐	☐	☐
During the past five (5) years, have you or any of your dependents:						
15. Consulted, been examined or treated by any physician or practitioner?	☐	☐	☐	☐	☐	☐
16. Had an X-ray, electrocardiogram or any laboratory test or study?	☐	☐	☐	☐	☐	☐
17. Had observation or treatment at a clinic, hospital or sanitarium?	☐	☐	☐	☐	☐	☐
18. Had or been advised to have a surgical operation?	☐	☐	☐	☐	☐	☐
19. Consulted a psychiatrist or psychologist?	☐	☐	☐	☐	☐	☐
20. Received medical treatment for any disease, condition or disorder not indicated above?	☐	☐	☐	☐	☐	☐
21. Are you or any of your dependents now pregnant? If 'Yes', state expected date of delivery.	☐	☐	☐	☐	☐	☐

If any of questions 1 – 21 are answered, 'Yes', give complete details below: [continue on additional sheet, if necessary]

Quest. No.	Full Name of Person Treated	Nature of Ailment	Date(s) of Visit(s)	Degree of Recovery (F = Full; P = Partial; C = Continuing)	Complete Name & Address of Attending Physician/Dentist

Authorization to Obtain and Release Information:

I declare that all statements are full, true and complete; I understand that they form the basis upon which any insurance will be made effective. I authorize my Physician, Hospital or any other medically related facility to disclose to Sagicor Life Jamaica Limited information about my health, habits or medical history as well as that of any dependents listed. It is further understood that Sagicor Life Jamaica Limited reserves the right to request an examination by a Physician of their choice.

Date: _____ **Signature of Employee:** _____

PART B – TO BE COMPLETED BY EMPLOYER [Continue on additional sheet if necessary]

1. Is the employee now at work and able to perform full duties? ☐ Yes ☐ No If 'No', give details _____
2. Is the employee employed full-time, working more than 30 hours every week? ☐ Yes ☐ No If 'No', give details _____
3. Has the employee been absent from work due to sickness or injury during the past 6 months? ☐ Yes ☐ No If 'Yes', give details _____
4. Do you know of any prior or existing serious physical impairment, history of drug abuse or alcoholism? ☐ Yes ☐ No If 'Yes', give details _____

Date: _____ Signature for Employer: _____ Title: _____