

GROUP HEALTH AND LIFE APPLICATION FORM

PLEASE COMPLETE IN BLOCK LETTERS

POLICY NO. LIFE _____ POLICY NO. HEALTH _____

SECTION A – APPLICANT INFORMATION

NAME OF POLICYHOLDER:	
NAME OF EMPLOYEE/INSURED:	DATE OF BIRTH:(dd/mm/yyyy)
EMAIL ADDRESS:	GENDER: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
TELEPHONE (Home): _____ (Work): _____ Ext: _____ (Cellular): _____	
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Common Law <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	OCCUPATION:
IDENTIFICATION (tick one) <input type="checkbox"/> DP <input type="checkbox"/> PP <input type="checkbox"/> ID (Please attach a copy) Number: _____	TYPE OF COVERAGE: <input type="checkbox"/> GROUP HEALTH <input type="checkbox"/> GROUP LIFE
EXTRA COVERAGE:(if applicable) <input type="checkbox"/> VOLUNTARY LIFE <input type="checkbox"/> DEPENDENT LIFE	

SECTION B – CO-ORDINATION OF BENEFITS

1. Are you or your spouse covered by any other Medical or Health Plan? Yes No

If Yes, please give (a) NAME OF PLAN: _____ (b) NAME OF INSURANCE COMPANY: _____

SECTION C – EMPLOYEE’S DEPENDENTS TO BE COVERED

RELATIONSHIP	NAME OF DEPENDENT/S	GENDER (M/F)	DATE OF BIRTH (dd/mm/yyyy)	EFFECTIVE DATE (dd/mm/yyyy)	COUNTRY OF RESIDENCE
SPOUSE					
CHILD					
CHILD					
CHILD					
CHILD					

A school letter is required every academic year for children attending full-time Tertiary school from age 19 to attainment of age 25.

SECTION D – BENEFICIARY INFORMATION (APPLICABLE TO GROUP LIFE ONLY)

RELATIONSHIP	NAME OF BENEFICIARY	GENDER (M/F)	DATE OF BIRTH (dd/mm/yyyy)	PERCENTAGE (%)

SECTION E – ACCOUNT INFORMATION FOR PAYMENT OF CLAIMS

ACCOUNT NUMBER: (confirm with copy of bank statement) <input type="text"/>	NAME OF BANK:
ACCOUNT TYPE: <input type="checkbox"/> SAVINGS <input type="checkbox"/> CHEQUING	NAME OF BRANCH:

I hereby apply for Registration as a Member of the Group Health Plan and/or Group Life Plan of the above Policyholder/Group and authorize deductions to be made by the Policyholder for contributions required to be paid by me in accordance with the terms and conditions of the Plan. I am familiar with the terms and conditions of the Plan and agree to be bound thereby. I also hereby declare that the above information is true and complete and shall form part of my application to Guardian Life of the Caribbean Limited.

EMPLOYEE SIGNATURE:	DATE: (dd/mm/yyyy)
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SECTION F – FOR OFFICIAL USE ONLY (TO BE COMPLETED BY THE POLICYHOLDER)

DATE EMPLOYED: (dd/mm/yyyy)	DATE OF CONFIRMATION: (dd/mm/yyyy)	EFFECTIVE DATE OF COVERAGE: (dd/mm/yyyy)
COVERAGE TIER: (tick as applicable) <input type="checkbox"/> SINGLE <input type="checkbox"/> EMPLOYEE + ONE <input type="checkbox"/> EMPLOYEE + FAMILY		IF GROUP LIFE, EMPLOYEE ANNUAL SALARY: TT\$ _____
PLAN ADMINISTRATOR: NAME: _____ SIGNATURE: _____ DATE: (dd/mm/yyyy) _____		PLACE COMPANY STAMP HERE: