

GROUP INSURANCE ENROLLMENT FORM

EMPLOYEE INFORMATION

Group Policy No.	Certificate No.	Occupation:	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Mr. <input type="checkbox"/>	Mrs. <input type="checkbox"/>	Ms. <input type="checkbox"/>
First Name		Middle Name		Last Name			
Address:							
Home/Cell No:	Date of Birth:	Coverage:	Do you wish to cover your dependents?				
Work No:	Day Month Year	Life <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>				
Email Address:		Medical <input type="checkbox"/>					
		Pension <input type="checkbox"/>					
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married Maiden Name..... <input type="checkbox"/> Separated <input type="checkbox"/> Widow(er) <input type="checkbox"/> Common Law <input type="checkbox"/> Divorced							

DEPENDENTS TO BE INSURED

1=Spouse	2=Common Law Spouse	3=Son	4=Daughter	5= Stepson	6= Stepdaughter
Name	Date of Birth	Relationship	Address		
	Day Month Year				
	Day Month Year				
	Day Month Year				
	Day Month Year				
	Day Month Year				
	Day Month Year				

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company or other organization, institution, person or medical information bureau that has or may hereafter have any records or knowledge of me or my health, to give such information to **DEMERARA MUTUAL LIFE ASSURANCE SOCIETY LIMITED**.

.....
Date

.....
Employee Signature

.....
Witness

TO BE COMPLETED BY EMPLOYER—SHOULD BE THOROUGHLY COMPLETED

First Employed	Day Month Year	EARNINGS <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually Basic Salary	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 per week for full pay. Company Stamp & Administrator Signature
Date Appointed	Day Month Year		
End of Waiting Period	Day Month Year		
Effective Date of Insurance	Day Month Year		

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BENEFICIARY DESIGNATION(S)

The sum of all Primary beneficiary(ies) must be equal to 100%. The sum of all Contingent beneficiary(ies) must be equal to 100%.

- P- Primary:** Person or entity to receive death benefits if Employee is deceased.
- C- Contingent:** Person or entity to receive death benefits if Primary Beneficiary(ies) predeceases the Employee.
- R- Revocable:** Primary Beneficiary can be changed at any time without written permission from that beneficiary.
- I- Irrevocable:** Primary Beneficiary cannot be changed without written permission from that beneficiary.

Full Name	Date of Birth	Relationship	Address	Primary or Contingent (P or C)	Revocable or Irrevocable (R or I)	% Share assigned to Beneficiary
	Day Month Year					
	Day Month Year					
	Day Month Year					
	Day Month Year					
	Day Month Year					

Name of Trustee if Beneficiary is a Minor:

WITNESSES – (Required if Beneficiaries are listed)

Name..... Signature.....
 Name..... Signature.....

I reserve the right to change the beneficiary appointed above subject to any statutory reasons. If the Group Insurance Plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay.

Date..... Employee Signature.....