Sagicor Life

GPASO & SUPPLEMENTAL ENROLLMENT FORM

PLEASE COMPLETE IN BLOCK CAPTIALS

NAME OF SUBSCRIBER (BIRTH CERTIFICATE MUST ACCOMPANY FORMS):

_____ _____ _____
FIRST NAME MIDDLE NAME SURNAME (AS SEEN ON PAY SLIP)

PENSION #: _____ **TRN**: _____ - _____ - _____ **GENDER**: Male ☐ Female ☐ **DATE OF BIRTH**:_____
MM / DD / YY

CELL NO.: (876) _____ - _____ **HOME NO**.: (876) _____ - _____ **PLAN TYPE:** INDIVIDUAL ☐ FAMILY ☐

MAILING ADDRESS: _____

_____ **EMAIL ADDRESS**: _____
PARISH

PENSION PAY SITE: _____

ELECTRONIC FUND TRANSFER (COMMERCIAL BANKING INFORMATION ONLY**):**

Name of Account Holder(s):	
Name of Bank:	
Branch (Name and Branch #):	
Account Number:	
Account Type:	Savings: ☐ Current/Chequing: ☐

DEPENDENT INFORMATION (GPASO --- SPOUSE ONLY) (BIRTH & MARRIAGE CERTIFICATE MUST ACCOMPANY FORMS):

FULL NAME (i.e. First, Middle Initial & Last)	RELATIONSHIP	Date of Birth MM / DD / YY	TRN

Supplemental Hospitalization Health Plan

Select your coverage level:

☐ Individual Coverage ☐ Family Coverage

The policy (ies) will be effected on receipt of the first month's premium. Please note that coverage becomes applicable once the requisite waiting period(s) have been served.

I authorize the release of information (Personal, Family, Bank and Tax Registration Number) to the Plan Administrator. I certify that the above information is correct and fully completed to the best of my knowledge. Failure to complete the form in its entirety will delay my enrollment with no refund. I confirm that I understand the conditions as stated above:

PENSIONER'S SIGNATURE: _____ **DATE**: _____/_____/_____
MM DD YY