Sagicor

SAGICOR MEDIGAP® FOR GOVERNMENT PENSIONERS

PAYROLL DEDUCTION AUTHORIZATION FORM

(Please fill form in block capital)

I _____

Christian Name *Initial* *Surname*

As a member of the Government Pensioners Administration Services Only contract with Sagicor Life Jamaica Limited, I elect Supplemental coverage for myself and on behalf of my eligible dependent(s). I authorize the Ministry/Department to deduct the additional monthly sum from my pension and forward to Sagicor in respect of my premium for Voluntary Benefits. I also authorize that within 30 days of notice, you shall act on any change to the initial payment order made by me or by Sagicor and approved by my Association in writing. This authority shall remain in force until you are advised that it is superseded by another or cancelled by me.

NAME OF PAY SITE: _____

NAME OF AGENCY/ MINISTRY _____

PENSIONER TRN: _____

Individual $ _____ Family $ _____

Pensioner No. _____

Signature _____

Date _____