Guardian Group
Guardian Life of The Caribbean Limited

# GROUP HEALTH AND LIFE APPLICATION FORM

**PLEASE COMPLETE IN BLOCK LETTERS** **POLICY NO. LIFE** _____ **POLICY NO. HEALTH** _____

## SECTION A – APPLICANT INFORMATION

**NAME OF POLICYHOLDER:** EVERMED

**NAME OF EMPLOYEE/INSURED:** | **DATE OF BIRTH:** *(dd/mm/yyyy)*

**EMAIL ADDRESS:** | **GENDER:** ☐ **MALE** ☐ **FEMALE**

**TELEPHONE (Home):** **(Work):** **Ext:** **(Cellular):**

**MARITAL STATUS:** ☐ **Single** ☐ **Married** ☐ **Common Law** ☐ **Divorced** ☐ **Widowed** | **OCCUPATION:**

**IDENTIFICATION** (tick one) ☐ **DP** ☐ **PP** ☐ **ID**
*(Please attach a copy)* **Number**: _____

**TYPE OF COVERAGE:**
☒ **GROUP HEALTH** ☐ ~~**GROUP LIFE**~~

~~**EXTRA COVERAGE:** *(if applicable)*~~
☐ ~~**VOLUNTARY LIFE**~~ ☐ ~~**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)*
| | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | |

**NAME OF BANK:**

**ACCOUNT TYPE:** ☐ **SAVINGS** ☐ **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:**
INSURED SIGNATURE:

**DATE:** *(dd/mm/yyyy)*

## 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)*
☐ **SINGLE** ☐ **EMPLOYEE + ONE** ☐ **EMPLOYEE + FAMILY**

~~**IF GROUP LIFE, EMPLOYEE ANNUAL SALARY:**~~
~~**TT$**~~_____

**PLAN ADMINISTRATOR:**

NAME: _____ SIGNATURE: _____

DATE : *(dd/mm/yyyy)*_____

**PLACE COMPANY STAMP HERE:**