Sagicor Life

TO BE COMPLETED BY THE MEMBER USING BLOCK LETTERS OR PRINT

CCRP MEMBER ENROLLMENT FORM

Group Policy Name: _____ Group Policy Number: _____ Member No: _____

Applicant's Name _____ _____ _____
First Middle Initial Last

Email: _____ Cellphone No: _____

Address: _____

Date of Birth: _____ Gender (M/F) _____ TRN: _____
DD/MM/YYYY

SELECT A PLAN OPTION:
You may choose one or both products listed below. Beneficiary information is required for the group life insurance policy

CCRP Comprehensive Group Health Insurance Plan

Dependent Details for Group Health Plan

First Name	Middle Initial	Last Name	Date of Birth DD/MM/YYYY	Gender	Relationship to You

AGE BAND 50-65 YEARS

	Quarterly	Semi-Annually	Annually
Member only	☐ $19,198.05	☐ $ 38,396.07	☐ $ 76,792.14
Member + One dependent	☐ $38,396.07	☐ $ 76,792.14	☐ $153,584.28
Member + Family	☐ $53,158.95	☐ $106,317.90	☐ $212,635.80

AGE BAND 66-70 YEARS

	Quarterly	Semi-Annually	Annually
Member only	☐ $21,368.43	☐ $ 42,736.86	☐ $ 85,473.72
Member + One dependent	☐ $42,736.86	☐ $ 85,473.72	☐ $170,947.44
Member + Family	☐ $59,236.76	☐ $118,473.51	☐ $236,947.02

AGE BAND 71-80 Years

	Quarterly	Semi-Annually	Annually
Member only	☐ $24,052.59	☐ $ 48,105.18	☐ $ 96,210.36
Member + One dependent	☐ $48,105.18	☐ $ 96,210.36	☐ $192,420.72
Member + Family	☐ $66,751.01	☐ $133,502.01	☐ $267,004.02

CCRP Group Life Insurance Plan - OPTIONAL

Death Benefit [ ] YES [ ] NO

J$500,000.00

Beneficiary Information

First Name	Middle Initial	Last Name	Allocation (%)	Relationship to you	Trustee

* If a child under the age of 18 years is named, a trustee must be assigned
** If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share

Select your premium payment mode: All Premiums quoted are inclusive of GCT

AGE BAND 50-80 YEARS

	Quarterly	Semi-Annually	Annually
Member only	☐ $7,380.00	☐ $14,760.00	☐ $29,520.00

GROUP INSURANCE STATEMENT OF HEALTH

PART A – TO BE COMPLETED BY THE EMPLOYEE USING BLOCK LETTERS OR PRINT

IMPORTANT: ALL QUESTIONS MUST BE ANSWERED USING 'YES', 'NO' OR 'N/A'

GROUP NAME:	MEMBER:
Group Policy Number:	Member's Date of Birth:
Occupation:	Effective Date:
	Height: Weight:

Eligible Dependents (Spouse/Children)	Relationship to Employee	Height	Weight	Date of Birth

Place Tick [√] in Box ……..

Have you or any of your dependents ever been diagnosed or treated for:	Member Yes	Member No	Spouse Yes	Spouse No	Children Yes	Children No
1. Any physical impairment?						
2. Epilepsy, nervous breakdown, or any disorder of the brain or nervous system?						
3. Tuberculosis or any disorder of the lungs, bronchial tubes, throat or respiratory system?						
4. Allergies, hay fever or asthma?						
5. Ulcer, colitis, or any disorder of the stomach, intestines, rectum, gall bladder or liver?						
6. Hemorrhoids or rectal polyps or any disorder of the prostate?						
7. Sugar or Albumin or blood in urine, or any disorder of the kidneys, urinary system, female or male organs, or breasts?						
8. Diabetes, gout or any disorder of the thyroid or other glands?						
9. Any disorder of the eyes, ears, skin, muscle, bones or joints?						
10. Cancer, tumour, cyst or lump?						
11. Any disorder of the blood, heart or circulatory system?						
12. HIV, Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)?						
13. Infertility, miscarriage or abortion?						
14. Any disorder or injury involving the spine or skeletal system?						
15. Arthritis, neuritis or rheumatism or any other connective tissue disorder?						
During the past five (5) years, have you or any of your dependents:						
16. Consulted, been examined or treated by any physician or practitioner?						
17. Had an X-ray, electrocardiogram or any laboratory test or study?						
18. Had observation or treatment at a clinic, hospital or sanitarium?						
19. Had or been advised to have a surgical operation?						
20. Consulted a psychiatrist or psychologist?						
21. Received medical treatment for any disease, condition or disorder not indicated above?.						

If any of questions 1 – 21 are answered, 'Yes', give complete details below: [continue on additional sheet, if necessary]

Quest. No.	Full Name of Person Treated	Nature of Ailment	Date(s) of Visit(s)	Degree of Recovery (F = Full; P = Partial; C = Continuing)	Complete Name & Address of Attending Physician/Dentist

Authorization to Obtain and Release Information:

I declare that all statements are full, true and complete; I understand that they form the basis upon which any insurance will be made effective. I authorize my Physician, Hospital or any other medically related facility to disclose to Sagicor Life Jamaica Limited information about my health, habits or medical history as well as that of any dependents listed. It is further understood that Sagicor Life Jamaica Limited reserves the right to request an examination by a Physician of their choice.

I elect coverage for myself, and where applicable, for my dependent(s) and agree to remit the premium outlined in the payment mode above. I declare that the answers shown above are complete and true and I understand they form the basis upon which insurance will be made effective. I understand no benefit(s) will be payable for pre-existing conditions before the coverage has been in effect for six (6) consecutive months.
Optional – Death Benefit
No death benefit, except where death is accidental, can be made before twelve (12) months and coverage under this plan is restricted to the maximum amount allowable per life insured.
I authorize my Physician, hospital or other medically related facility to disclose to Sagicor Life Jamaica Limited any additional information about my health habits or my medical history.

Date:_____ **Signature of Member:** _____