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: PSCU CREDIT UNION

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 22 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:	**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:** **BD$**_____
PLAN ADMINISTRATOR: NAME: _____ SIGNATURE: _____ DATE : *(dd/mm/yyyy)*_____		**PLACE COMPANY STAMP HERE:**