Beacon

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GROUP INSURANCE ENROLMENT CARD

DO NOT COMPLETE SHADED AREAS

POLICY NO. LIFE AD&D

POLICY NO. HEALTH

EFFECTIVE DATE MTH DAY YEAR

DATE OF BIRTH MTH DAY YEAR

SEX M ☐ F ☐

APPLICATION'S NAME (SURNAME FIRST) USE BLOCK LETTERS

AMOUNT OF LIFE INSURANCE

AMOUNT OF AD&D INSURANCE

HEALTH INSURANCE YES ☐ NO ☐

DATE CONFIRMED MTH DAY YEAR

DATE OF EMPLOYMENT MTH DAY YEAR

RATE GR. LIFE/OOO

EFFICTIVE DATE MTH DAY YEAR

RATE AD&D/OOO

EFFECTIVE DATE MTH DAY YEAR

RATE GR.HEALTH

EFFECTIVE DATE MTH DAY YEAR

SINGLE ☐ **FAMILY** ☐

HAVE YOU ANY OTHER FORM OF INSURANCE? TICK √

☐ MOTOR ☐ FIRE ☐ BURGLARY ☐ MARINE ☐ IND. LIFE ☐ OTHER

BENEFICIARY'S NAME/BLOCKLETTERS (SURNAME FIRST)

BENEFICIARY'S RELATIONSHIP TO APPLICATION

CERTIFICATE NO.

MARITAL STATUS

I WISH TO INSURE MY ELIGIBLE DEPENDANTS * ☐ YES ☐ NO

APPLICANT'S ADDRESS

APPLICANT OCCUPATION

APPLICANT'S EARNINGS

HOW ARE EARNINGS PAYABLE
☐ Hourly ☐ Weekly ☐ Monthly ☐ Annually

DO YOU HAVE ANY MEDICAL COVERAGE? IF YES SPECIFY.

POLICY HOLDER
☐ ASSOCIATION ☐ EMPLOYER ☐ CREDIT UNION ☐ UNION

** IF YES, LIST OVERLEAF*

I HERBY apply for insurance under Policyholder's Group Plan and Authorize the deduction form my pay (if applicable) of any contribution I must make towards the cost of these or any future benefits. I also agree to produce evidence of age if required. If any beneficiary named above dies before me the interests of such beneficiary shall unless otherwise provided above accrue to the surviving beneficiaries of beneficiary or if none of my estate. I reserve the right to change any beneficiary named above.

Applicant's Signature

Policyholder's Name

Date

DEPENDANTS TO BE INSURED

NAME	DATE OF BIRTH	RELATIONSHIP	EFFECTIVE DATE OF COVERAGE

FOR OFFICAL USE ONLY CLASS: NEWCLASS:	REMARKS
EFFECTIVE DATE OF CHANGE	