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GROUP INSURANCE ENROLMENT CARD

PLEASE COMPLETE FORM IN BLOCK LETTERS

POLICYHOLDER NAME T T P C U

ASSOCIATION ☐ EMPLOYER ☐ CREDIT UNION ☐ UNION ☐

APPLICANT'S SURNAME

DATE OF BIRTH *m m d d y y*

SEX M ☐ F ☐

APPLICANT'S FIRST NAME

MARITAL STATUS
SINGLE ☐ MARRIED ☐

DO YOU HAVE ANY OTHER FORM OF INSURANCE? TICK √

MOTOR ☐ FIRE ☐ BURGLARY ☐ MARINE ☐ LIFE ☐ MEDICAL ☐ IF YES, SPECIFY: ____________________

BENEFICIARY'S NAME (SURNAME FIRST) - *applicable to health/life*

BENEFICIARY'S RELATIONSHIP TO APPLICANT

APPLICANT'S OCCUPATION

APPLICANT'S EARNINGS NOT APPLICABLE

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

DATE EMPLOYED NOT APPLICABLE *m m d d y y*

DATE CONFIRMED NOT APPLICABLE *m m d d y y*

EFFECTIVE DATE NOT APPLICABLE *m m d d y y*

AMOUNT OF LIFE INSURANCE

AMOUNT OF AD&D INSURANCE

HEALTH INSURANCE
YES ☐ NO ☐

DEPENDENTS TO BE COVERED?*
YES ☐ NO ☐
**If Yes, list below*

EMPLOYEE CATEGORY: EMPLOYEE ONLY ☐ EMPLOYEE & ONE ☐ EMPLOYEE & FAMILY ☐

ELIGIBLE DEPENDANTS TO BE INSURED

NAME	DATE OF BIRTH	RELATIONSHIP	EFFECTIVE DATE OF COVERAGE
NOT APPLICABLE			

I HEREBY apply for insurance under Policyholder's Group Plan and Authorize the deduction from 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 or beneficiary or if none of my estate. I reserve the right to change any beneficiary named above.

Applicant's Signature ____________ Policyholder's Signature & Stamp ____________ Date ____________

FOR OFFICIAL USE ONLY E. Only ☐ E. + One ☐ E. + Family ☐	**REMARKS**
EFFECTIVE DATE OF CHANGE:	

PLEASE TURN OVER