THE MARITIME FINANCIAL GROUP

MARITIME LIFE (CARIBBEAN) LIMITED

GROUP HEALTH PLAN ENROLLMENT CARD

THIS SIDE TO BE COMPLETED BY THE EMPLOYEE. PLEASE PRINT ALL DETAILS.

FULL NAME _____

HOME ADDRESS _____ TEL. NOS. _____

_____

SEX	
MALE	FEMALE

DATE OF BIRTH		
DD	MM	YYYY

COVERAGE		
Life	A. D. & D.	Health

TYPE OF COVERAGE	
Single	
Single & One	
Family	

BENEFICIARY _____

RELATIONSHIP _____

I wish to apply for membership under the Group Plan, for which I am, or may become eligible. If approved, I agree to the deduction of the appropriate contribution from my salary and to produce evidence of age if required.

SIGNATURE OF PERSON ENROLLING _____ DATE _____

PLEASE LIST BELOW THE NAME(S) OF SPOUSE AND UNMARRIED CHILDREN UNDER 19 YEARS WHO ARE TO BE COVERED

LIST IN ORDER OF AGE, OLDEST FIRST

NAME	RELATIONSHIP	DATE OF BIRTH			AGE
		DD	MM	YYYY	

THIS SECTION TO BE COMPLETED BY THE EMPLOYER, UNION OR ASSOCIATION

1. Name of Employer, Union or Association _____
2. Name of person enrolling _____
3. Date entered into service _____
4. Occupation _____

Rate of Pay $_____ Wk ☐ Mth ☐ Yr ☐ Premium _____

Checked and signed on behalf of the Employer, Union or Association

Signature _____ Official Stamp