NAGICO INSURANCES

GROUP INSURANCE ENROLLMENT FORM

Group Policy No.	Certificate No.	Occupation:	Male ☐ Female ☐	Mr. ☐ Mrs. ☐ Ms. ☐
First Name	Middle Name	Last Name		
Address:				
Telephone No: Home: Work:	Date of Birth: Day | Month | Year	Coverage: ☐ Life ☐ Health	No. of Dependents including Spouse?	
Marital Status: ☐ Single ☐ Married ☐ Common Law	Do you wish to cover your Dependents? ☐ Yes ☐ No	Beneficiary: (Applies to LIFE coverage only)	Relationship:	

BENEFICIARY WITNESSES - (Required if Beneficiaries are listed)

1. Name: _____ Signature _____

2. Name: _____ Signature _____

I reserve the right to change the beneficiary appointed above subject to any statutory reasons. If the Group Insurance Plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay.

_____ Date

_____ Signature

TO BE COMPLETED BY EMPLOYER - SHOULD BE THOROUGHLY COMPLETED

First Employed Day | Month | Year	EARNINGS ☐ Weekly ☐ Monthly ☐ Annually	This employee has been continuously employed by us since the date of his/her employment shown and is at present working a minimum of 30 hours per week for full pay.
Date Appointed Day | Month | Year		
End of Waiting Period Day | Month | Year		
Effective Date of Insurance Day | Month | Year	Salary _____	_____ Company Stamp & Administrator Signature

DEPENDENTS TO BE INSURED

Relationships: Spouse, Common Law Spouse, Son, Daughter, Stepson or Stepdaughter

Name	Date of Birth	Relationship	Address
	Day | Month | Year		
	Day | Month | Year		
	Day | Month | Year		
	Day | Month | Year		
	Day | Month | Year		
	Day | Month | Year		
	Day | Month | Year		
	Day | Month | Year		