Tatil
... where people are people

MEMBER HEALTH APPLICATION FORM
GROUP HEALTH PLAN

TRINIDAD AND TOBAGO INSURANCE LIMITED

I am a member of the:				**Credit Union**
Name of Member:				
Nationality:			**Occupation:**	
Date of Birth:			**Sex:** ☐ **Male** ☐ **Female**	
Coverage:	☐ **Member Only**	☐ **Member & One Dependent**	☐ **Member & Family**	
Marital Status:	☐ **Single**	☐ **Married**	☐ **Widowed**	☐ **Divorced**
Address:				
Phone Numbers: (H)			**(M)**	
Email Address 1:			**Email Address 2:**	
National ID Card:			**Passport No:**	
Driver's License:				
Are you or your spouse covered by any other medical plan? If Yes				

	Name of Plan/Group	Name of Insurance Company
Member:		
Spouse:		

Applying for the Health Coverage option of:

Members up to Age 65	☐ **$300,000.00**	☐ **$500,000.00**
Members over age 65	☐ **$300,000.00**	

Applying for the Life Coverage option of:

Members up to Age 60	☐ **$20,000**	☐ **$50,000**

Beneficiary:	
Date of Birth:	**Relationship:**

I hereby apply for registration as a Member of the Credit Union's Group Health Plan and agree to the payment of the premiums for my continued coverage under the Policy, in accordance with the terms and conditions of the Plan and agree to be bound thereby. I nominate the person named above as beneficiary to receive any amounts which may be payable in the event of my death.

Member's Signature	**Date**

MEMBER'S DEPENDENTS TO BE COVERED

Name of Dependent(s):	Relationship	Sex	Date of Birth

TO BE COMPLETED BY CREDIT UNION

Authorized Signature:	**Title:**
Credit Union Stamp:	**Date:**

TO BE COMPLETED BY TATIL

Effective Date of Member's Coverage:	
Class/Coverage:	**Health Rate:**
Policy No. Health:	
Cert. No. Health:	