

# Group Life and Loss of Income Enrolment Form



FOR BF&M OFFICIAL USE	
POLICY NUMBER _____	REMARKS _____
CERTIFICATE NUMBER _____	_____
EFFECTIVE DATE _____	_____
ENTRY NUMBER _____	_____

## COMPLETE FOR EMPLOYEE LIFE AND LOSS OF INCOME COVERAGE (PLEASE PRINT)

GROUP POLICY NAME			GROUP POLICY NUMBER					
EMPLOYEE NAME			DATE OF BIRTH					
LAST	FIRST	MIDDLE	DAY	MONTH	YEAR			
GENDER		MARITAL STATUS						
MALE ( ) FEMALE ( )		MARRIED ( ) SINGLE ( )						
ADDRESS								
TELEPHONE NUMBER			EMAIL ADDRESS					
OCCUPATION			DATE OF EMPLOYMENT		ANNUAL SALARY			
			DAY	MONTH	YEAR			
NAME OF BENEFICIARY			RELATIONSHIP TO INSURED		DATE OF BIRTH			
LAST	FIRST	MIDDLE		DAY	MONTH	YEAR		
LAST	FIRST	MIDDLE		DAY	MONTH	YEAR		
LAST	FIRST	MIDDLE		DAY	MONTH	YEAR		
Trustee required if Beneficiary is under the age of 18 years.								
NAME OF TRUSTEE			RELATIONSHIP TO INSURED		DATE OF BIRTH			
LAST	FIRST	MIDDLE		DAY	MONTH	YEAR		
LAST	FIRST	MIDDLE		DAY	MONTH	YEAR		
LAST	FIRST	MIDDLE		DAY	MONTH	YEAR		
TELEPHONE NUMBER			EMAIL ADDRESS					
EMPLOYER'S SIGNATURE			EMPLOYEE'S SIGNATURE					
PRINT NAME			DATE		PRINT NAME	DATE		
			DAY	MONTH	YEAR	DAY	MONTH	YEAR