

**PLEASE COMPLETE IN BLOCK CAPITALS**

NAME OF SUBSCRIBER (BIRTH CERTIFICATE MUST ACCOMPANY FORM)

FIRST NAME	MIDDLE NAME	SURNAME	MAIDEN NAME
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EMP #: \_\_\_\_\_ TRN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ GENDER: Male  Female  DATE OF BIRTH: \_\_\_\_\_

CELL NO.: (876) \_\_\_\_\_ - \_\_\_\_\_ WORK NO.: (876) \_\_\_\_\_ - \_\_\_\_\_ HOME NO.: (876) \_\_\_\_\_ - \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

PARISH \_\_\_\_\_

PLAN TYPE: INDIVIDUAL  IND+1  FAMILY  PREVIOUS POLICY NO: \_\_\_\_\_

MINISTRY/DEPARTMENT/AGENCY/SCHOOL: \_\_\_\_\_ LOCATION/DIVISION: \_\_\_\_\_

EMPLOYMENT STATUS: TEMPORARY  CONTRACTUAL  PERMANENT  RETIRED  EFFECTIVE DATE: \_\_\_\_\_

GROUP: GEASO  GPASO  PUBLIC SECTOR MEDICAL OFFICER  EXECUTIVE SENIOR GOVERNMENT

CLASSIFICATION: POLICE  DISTRICT CONSTABLE  TEACHER  NURSE  CIVIL SERVANT

**ELECTRONIC FUND TRANSFER (COMMERCIAL BANKING INFORMATION ONLY):**

Name of Account Holder(s):	
Name of Bank:	
Branch:	
Account Number:	
Account Type:	Savings: <input type="checkbox"/> Current/Chequing: <input type="checkbox"/>

**DEPENDENT INFORMATION (SPOUSE & OR CHILD/CHILDREN-UNDER 18 YEARS ONLY) BIRTH CERTIFICATE MUST ACCOMPANY FORMS:**

FULL NAME <small>(i.e. First, Middle Initial &amp; Last)</small>	RELATIONSHIP	Date of Birth <small>MM / DD / YY</small>	TRN

**FOR GEASO EMPLOYEES ONLY – PERSONAL ACCIDENT – ACCIDENT DEATH AND DISMEMBERMENT**

*I do hereby revoke any previous designation or appointment of beneficiary(ies) with respect to the said Government Employees Administrative Services Only (GEASO) Accident Death and Dismemberment Group Policy and subject to the conditions set forth below, I designate and appoint the following beneficiary(ies):*

**BENEFICIARY INFORMATION:**

FULL NAME <small>(i.e. First, Middle and Last)</small>	DATE OF BIRTH <small>MM / DD / YY</small>	RELATIONSHIP	ALLOCATION (%)

**TRUSTEE FOR MINOR(S) NAMED ABOVE**

Name of Trustee: \_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
(i.e. First, Middle and Last) MM DD YY

I authorize the release of information (Personal, Family, Bank and Tax Registration Number) to the Plan Administrator. I certify that the above information is correct to the best of my knowledge and confirm that I understand the conditions as stated above:

EMPLOYEE'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
MM DD YY