ARGUS
Our Interest is You.

Group Insurance Enrolment Form

Group Health Insurance
Group Life and Disability Insurance
Bermuda Life Insurance Company Limited

Employee: Complete Sections B, C and D **Employer:** Complete Sections A, E and sign

A. Name of Employer

Employer Name	Group/Account Number

B. Employee Statement

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss Sex ☐ M ☐ F

Last Name	First Name	Middle Initial	Date of Birth (MM/DD/YY)

Work Phone	Home Phone	Cell Phone	Email

Previous Employer	

C. Dependent Coverage – For Group Health Insurance Only

Country of Residence ☐ Bermuda ☐ Other (Specify)_____

What level of coverage do you need for your spouse?
☐ None (assumes spouse is employed)
☐ Full (assumes non-working spouse)
☐ Supplemental (assumes working spouse with Act Benefits only)

Do you need coverage for your children? ☐ NO ☐ YES

Note: Eligible children are unmarried children under 19 years of age, or up to 26 years if enrolled in and in full-time attendance at a recognized school, college or university, or over age 19 if incapable of self-support due to a mental or physical disability.

Last Name	First Name	Middle Initial	Sex	Date of Birth (MM/DD/YY)
Spouse				
Child				
Child				
Child				
Child				

School Information: Note: for all children attending school overseas or 19 years of age or older and in a recognized school, college or university.

First Name of Child	Name of School, College or University	Location

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Beneficiary for Life Insurance Only

Note: The appointment of children under age 18 (current age of majority) is discouraged, as minors cannot give a valid receipt and discharge for benefits payable in the event of death for life insurance. However, if it is necessary to nominate children, a responsible adult should be appointed to receive the proceeds in trust for the benefit of the children.

Last Name	First Name	Middle Initial	Sex	Date of Birth (MM/DD/YY)	Relationship	% of Benefits

Trustee - Complete if the child is under age 18

Child's Name	Trustee Name	Date of Birth (MM/DD/YY)	Email	Phone Number

D. Signature of Employee

I hereby apply for the benefits for which I am or may become eligible under the Group Policy as issued to my Employer and authorize the required deductions, if any, from my pay. I also authorize any Provider of Services, as defined in the Policy, to supply any information required by Argus, in connection with any claim for benefits submitted to it on behalf of my dependents and myself.

Employee Signature Date (MM/DD/YY)

E. Employer Statement

Select Insurance Required Note: For Voluntary Life & Spousal Life, employee to complete the Application for Voluntary Life Insurance Form.

☐ Act Benefits Only ☐ Full Health Benefits ☐ Worker's Compensation
☐ Life ☐ Voluntary Life ☐ Long Term Disability ☐ Short Term Disability

Date Employed Full Time (MM/DD/YY)	Occupation	Health Class	Annual Earnings (for Life and LTD only)
			$

This employee has been actively at work since the date shown and is presently working full time and for full pay.

Signature of Authorized Employer Representative Date (MM/DD/YY)

For Argus Use Only

Group/Account	Location	Participant ID	Health Effective Date (MM/DD/YYYY)	Life Effective Date (MM/DD/YYYY)	LTD Effective Date (MM/DD/YYYY)	STD Effective Date (MM/DD/YYYY)