Sagicor

DIRECT CREDIT AUTHORISATION
for Group Health Insurance Claim Settlement

All fields are mandatory. Incomplete forms will not be processed.

1. INSURED INFORMATION

Full Name of Insured Account Holder *(First Name Initial Last Name)*	**National Identification Number**

E-mail Address

Telephone Number		
(Home)	*(Work)*	*(Cell)*

2. INSURANCE INFORMATION

Name of Policyholder / Company
Sagicor ID Number ***(See CariCARE Card)***

3. ACCOUNT INFORMATION

Name of Bank	**Branch**

Account Number to be Credited	**Transit Number**

1. I, the undersigned Insured Account Holder, hereby authorise Sagicor Life Inc. ("Sagicor") to credit my Account with all payments due to me in settlement of claims payable under the Policy. Amounts so credited shall constitute valid discharge of payment obligations to me under the Policy.

2. This authorisation revokes and replaces all previous direct credit authorisations and shall continue to be in force until such time as I shall have expressly revoked it by at least 10 days written notice delivered to Sagicor at its office. Any change in the account to be credited must be notified to Sagicor by filing a new Direct Credit Authorisation at least 10 days before the change is to become effective.

3. It is understood and agreed that Sagicor shall not be required to obtain and will not seek confirmation or verification of the account information provided by me from the Bank or any third party and shall not be liable for any loss resulting from the inaccuracy of the information provided or from failure to notify Sagicor of a change of account in the manner provided for herein.

4. Any delivery of this authorisation to the Bank shall constitute delivery by the undersigned.

5. Sagicor may in its absolute discretion terminate this arrangement with immediate effect by written notice sent to my last known address on record.

Signature of Insured Account Holder as recorded at Bank	Date

Signature of Witness	Name of Witness

INTERNAL USE ONLY

Checked by: _____ Date: _____