Guardian Group
live easy

COOPMED ADVANTAGE HEALTH ENROLMENT CARD

Name of Credit Union _____

Name of Member _____

(First Name) (Middle Name) (Surname)

Address of Employee _____

SEX

Male ☐

Female ☐

MARITAL STATUS

Single ☐ Widowed ☐

Married ☐ Divorced ☐

BIRTH DATE

Day Mth. Yr.

OCCUPATION _____

Phone (H) _____ (W) _____ (C) _____

No. of Dependents to be covered _____

Do you have any other Medical Coverage?

Email _____ Co. Insured With _____

DEPENDENTS

Name of Dependent	Relationship to covered Employee	Date of Birth	Effective Date of Coverage	Address of Dependent

Beneficiary _____ Relationship _____

(Full Name)

Witness (2) _____ _____

(First Name) (Surname) (Signature)

I hereby apply for Registration as a member of the **CoopMED Advantage Health Insurance Plan** and authorise my Employer to deduct from my wages, salary or earnings, the contributions required to be paid by me, if any, in accordance with the terms and conditions of the Plan. I nominate the person named above as beneficiary to receive any amounts which may be payable in the event of my death. I am familiar with the terms and conditions of the Plan and agree to be bound thereby.

Date _____ Applicants' full Signature _____

Effective Date of Coverage _____ Class

Date entered Employment _____ New Class _____ Eff. Date of Change _____

Earnings – Weekly _____ Coverage _____ Life ☐
Monthly
Annually

Health ☐

NIS# _____

FOR OFFICE USE

FOR OFFICIAL USE ONLY		
POLICY NO:		
CERTIFICATE NO:		