THE GUYANA AND TRINIDAD MUTUAL LIFE INSURANCE COMPANY LIMITED

Application for the GTM AcciProtect

Information About You - The Proposed Insured

First Name _____

Middle Name _____

Last Name _____

Address _____

_____

_____

Date of Birth: DD / MM / YY Age Last Birthday _____

Gender: ☐ M ☐ F Telephone No: (H) _____ (O) _____

GTM Insurance agent (If any) _____

_____

Select Coverage Desired

Plan Applied For - Check one ☑

EC$25,000 EC$50,000 EC$100,000

☐ Single Coverage

☐ Joint Coverage (Spouse)

Note: You will enjoy one month of free coverage once you pay your premiums annually.

Spouse Information - If Joint Coverage Chosen

First Name _____

Middle Name _____

Last Name _____

Date of Birth: DD / MM / YY Age Last Birthday _____

Gender: ☐ M ☐ F

Beneficiary

First Name _____

Middle Name _____

Last Name _____

Relationship to you _____

Date of Birth _____

Declaration

Agreement: I hereby apply for the GTM AcciProtect plan for the coverage selected above. I understand that this coverage will become effective as soon as my fully completed and signed application form is received by The Guyana & Trinidad Mutual Life Insurance Company and the first premium has been paid during my life.

Medical Authorisation: For claim purposes, I hereby authorise any physician, hospital, clinic, insurance company, or other organisation, institution or government office that has medical information about me to provide The Guyana and Trinidad Mutual Life Insurance Company with any such information. A photocopy of this authorisation shall be as valid as the original.

Dated at _____the _____day of _____

in the year _____

Signature of _____
Proposed Insured

Witness _____