canopy health insurance

SUPPLEMENTAL INSURANCE

PLEASE USE CAPITAL LETTERS
WHEN COMPLETING THIS FORM

PERSONAL INFORMATION

Name of Employer

SURNAME FIRST NAME M.I.

Name of Employee

D D M M M Y Y

Date of Birth

M F

Gender

Employee Tax Registration Number

OPTION ELECTED

☐ Plan 1 ☐ Plan 2 ☐ Plan 3

MONTHLY PREMIUMS

Employee $

Employee + 1 Dependent $

Employee + 2 or more Dependent $

In accordance with the options provided under my Employer's Group Health Insurance Policy, underwritten by Canopy Insurance Limited, I elect coverage as indicated above and hereby authorize my Employer to deduct the amount of Dollars $ from my salary, commencing D D M M M Y Y . The amount is to be submitted to Canopy Insurance Limited on a monthly basis to cover premiums, in respect of Supplemental Health Insurance. This authority shall remain in effect until cancelled by me, or replaced with another authorization.

Authorized Signature

Authorized Signature on behalf of Employer

Date

Company Stamp