TWCU CREDIT UNION CO-OPERATIVE SOCIETY LIMITED

GROUP HEALTH & LIFE INSURANCE PLAN

Provisor - Schedule of Benefits – Health Plan

Benefits /Items	Maximum Figures
Major Medical Benefits – Active Members: 3 years renewable	Option 1 - $ 300,000 Option 2 - $ 500,000 Option 3 - $ 1,000,000
Deductible	$500
Doctor's Visit	$300
Dental Benefit Deductible	$2,500 $150
Vision Care Deductible	$1,200 $150
Specialists - Office Visit	$400
Specialists -Hospital/Home Visits	$500
Diagnostic Services –per Disability	75%
Prescribed Drugs/Injections	75%
Maternity	$5,000
Physiotherapy –per Visit Maximum No. of visits per Calendar Year	$150 20
Preventative Care	$1,200
Hospital Room & Board – Daily Limits	$700 In the Caribbean 75% Elsewhere
Intensive Care – Daily Limits	$1,000 In the Caribbean $4,000 Elsewhere
Air Fare Max. Trips per Year	$5,000 2
Psychiatric – per Treatment Max. Treatments per Calendar Year	$500 20
Acupuncture Max. Visits per Calendar Year	$200 20
Chiropractic Max. Visits per Calendar Year	$200 20
Home Nursing Care Max No. of Days per Disability	$250 30
Repatriation of Mortal Remains	$ 20,000
Emergency Air Ambulance	US $18,000

Health Plan - Internal Lifetime Plan Limits

Items	Limits
Congenital Birth Defects	$100,000
Nervous & Mental Disorder	$25,000
AIDS/HIV	$50,000 50% of Major Medical
Durable Medical Equipment	$10,000
Radiation & Chemotherapy	75%
Dialysis	75%

Monthly Premiums

Monthly Premiums for (Members under 65 yrs)	Member Only	Member & One	Member & Family
Option 1 - $300,000	$331.00.	$563.00	$925.00
Option 2 - $500,000	$375.00	$656.00	$1,031.00
Option 3 - $1,000,000	$500.00	$875.00	$1,375.00

Group Life / Accidental Death & Dismemberment Plans – Available As An Add-On to the Health Plan

Benefit/ Item	Option 1	Option 2
Active -	Under 65	Years of Age
Group Life Sum Assured – Active	$50,000	$100,000
Accidental Death – Active	$50,000	$100,000
Monthly Premium – Active	$22	$44

JOIN TODAY !! …

This Plan is only available to Members of TWCU who are under the age of sixty-five (65).

#31 Pembroke Street, POS
Tel : 623-4444/ 3441 *Fax: 627-0822*
Email: info@twcu.co.tt Website: www.twcu.co.tt

Provider: Guardian Life of the Caribbean Limited.
Administrator: CIC Insurance Brokers Limited.

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Guardian Group
Guardian Life of The Caribbean Limited

GROUP HEALTH AND LIFE APPLICATION FORM

PLEASE COMPLETE IN BLOCK LETTERS

POLICY NO. LIFE _____ POLICY NO. HEALTH _____

SECTION A – APPLICANT INFORMATION

NAME OF POLICYHOLDER:

NAME OF EMPLOYEE/INSURED: | DATE OF BIRTH: (dd/mm/yyyy)

EMAIL ADDRESS: | GENDER: ☐ MALE ☐ FEMALE

TELEPHONE (Home): (Work): Ext: (Cellular):

MARITAL STATUS: ☐ Single ☐ Married ☐ Common Law ☐ Divorced ☐ Widowed | OCCUPATION:

IDENTIFICATION (tick one) ☐ DP ☐ PP ☐ ID
(Please attach a copy) Number: _____

TYPE OF COVERAGE:
☐ GROUP HEALTH ☐ GROUP LIFE

EXTRA COVERAGE: (if applicable)
☐ VOLUNTARY LIFE ☐ DEPENDENT LIFE

SECTION B – CO-ORDINATION OF BENEFITS

1. Are you or your spouse covered by any other Medical or Health Plan? ☐ Yes ☐ No

If Yes, please give (a) NAME OF PLAN: (b) NAME OF INSURANCE COMPANY:

SECTION C – EMPLOYEE'S DEPENDENTS TO BE COVERED

RELATIONSHIP	NAME OF DEPENDENT/S	GENDER (M/F)	DATE OF BIRTH (dd/mm/yyyy)	EFFECTIVE DATE (dd/mm/yyyy)	COUNTRY OF RESIDENCE
SPOUSE					
CHILD					
CHILD					
CHILD					
CHILD					

A school letter is required every academic year for children attending full-time Tertiary school from age 19 to attainment of age 25.

SECTION D – BENEFICIARY INFORMATION (APPLICABLE TO GROUP LIFE ONLY)

RELATIONSHIP	NAME OF BENEFICIARY	GENDER (M/F)	DATE OF BIRTH (dd/mm/yyyy)	PERCENTAGE (%)

SECTION E – ACCOUNT INFORMATION FOR PAYMENT OF CLAIMS

ACCOUNT NUMBER: (confirm with copy ofbank statement)
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

NAME OF BANK:

ACCOUNT TYPE: ☐ SAVINGS ☐ CHEQUING

NAME OF BRANCH:

I hereby apply for Registration as a Member of the Group Health Plan and/or Group Life Plan of the above Policyholder/Group and authorize deductions to be made by the Policyholder for contributions required to be paid by me in accordance with the terms and conditions of the Plan. I am familiar with the terms and conditions of the Plan and agree to be bound thereby. I also hereby declare that the above information is true and complete and shall form part of my application to Guardian Life of the Caribbean Limited.

EMPLOYEE SIGNATURE: | DATE: (dd/mm/yyyy)

SECTION F – FOR OFFICIAL USE ONLY (TO BE COMPLETED BY THE POLICYHOLDER)

DATE EMPLOYED: (dd/mm/yyyy) | DATE OF CONFIRMATION: (dd/mm/yyyy) | EFFECTIVE DATE OF COVERAGE (dd/mm/yyyy)

COVERAGE TIER: (tick as applicable)
☐ SINGLE ☐ EMPLOYEE + ONE ☐ EMPLOYEE + FAMILY

IF GROUP LIFE, EMPLOYEE ANNUAL SALARY:
TT$_____

PLAN ADMINISTRATOR:

NAME: _____ SIGNATURE: _____

DATE : (dd/mm/yyyy)_____

PLACE COMPANY STAMP HERE: