VIPCA
Virgin Islands Professional Charter Association

Enrollment Form

PART 1

○ Employee Only	○ Employee + Spouse	○ Employee + Child(ren)	○ Employee + Family
☐ $1,000	☐ $3,500	☐ $5,000	☐ Dental
Vessel/Company Name:		Employee Email Address:	
Employee Name: (Last)	(First)	(Middle)	
○ Male ○ Female	Height:	Weight:	
Position on Vessel:			
Address:			
Country:	Country of Citizenship:	Telephone:	
Social Security or Passport #:		Issuing Country:	
Date of Birth: (mm/dd/yyyy)		Requested Effective Date: (mm/dd/yyyy)	
VIPCA Membership ID #:		VIPCA Membership Start Date:	

PART 2

Dependent Information: *Attach a separate sheet, if needed*

Name (Last, First, Middle)		Date of Birth & Date of Marriage for Spouse	Height & Weight	Social Security or Passport #	Country of Citizenship
Spouse	○ Male ○ Female				
1st Child	○ Male ○ Female				
2nd Child	○ Male ○ Female				
3rd Child	○ Male ○ Female				

For dependent children age 19 or older, please indicate name and address of college or university and number of hours enrolled:

PART 3

Current Coverage Information: *Please provide a copy of benefit summary if possible*
Current Carrier Name:
Current Carrier Policy Number:
Current Carrier Phone Number:
Current Subscriber:
Effective/Termination Dates:

PART 4

I hereby certify that I have read the above statements and all attachments or they have been read to me and the statements are true and complete to the best of my knowledge and belief. I understand that any misrepresentation contained herein will void the insurance and all claims will be forfeited. I understand that no coverage is effective until I am notified in writing by the Company, and the Company has the right to refuse to grant coverage. The undersigned authorizes any licensed doctor, practitioner of the healing arts, hospital, clinic, health related facility, pharmacy, government agency, insurance agency, insurance company, group policy holder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis or prognosis of any physical or mental condition, or the financial and employment status of the individual to provide this information to CIGNA Global Medical.

Employee Signature:_____ Date: _____
(mm/dd/yyyy)

Spouse Signature: _____ Date: _____
(mm/dd/yyyy)