



# TEAM MEMBER SIGNATURE FORM

AGWM Personnel and Member Care

**Team members that hold a volunteer card do not need to complete this form.**

## TEAM MEMBER CONTACT INFORMATION

Full Legal Name \_\_\_\_\_ Trip ID # \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Previous Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Phone (include area code) \_\_\_\_\_ Email Address \_\_\_\_\_

Have you been on a missions trip since October 2009?  Yes  No  Not sure

## EMERGENCY CONTACT INFORMATION (Must be someone NOT going on trip.)

Name of Emergency Contact Person \_\_\_\_\_ Relationship to Team Member \_\_\_\_\_

Home Phone (include area code) \_\_\_\_\_ Cell Phone (include area code) \_\_\_\_\_ Work Phone (include area code) \_\_\_\_\_

**Team members under the age of 18 do not need to complete the sections below.**

## GTL INSURANCE BENEFICIARY DESIGNATION

Benefits payable for loss of life are payable to the first surviving classes of the covered person: spouse; children; parent; siblings; or estate, unless otherwise indicated below.

Policy Number: 24N-018-001-Q

**Beneficiary Information**

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Relationship to Insured \_\_\_\_\_ If you are 65 or older, do you receive Medicare?  Yes  No

## SIGNATURE

**By signing my name below, I hereby state that I have read and agree to the terms and conditions of the Assumption of Risk, Code of Conduct, and the above GTL Insurance Beneficiary Designation.**

Signature Field \_\_\_\_\_ Date \_\_\_\_\_