CUNA CARIBBEAN INSURANCE

RESET

THE FAMILY CRITICAL ILLNESS PLAN ENROLMENT FORM

SECTION I - Primary Insured Information

1. Have you previously had a Family Critical Illness Plan certificate? ◯ YES ◯ NO
2. Are you or any person(s) who will be enrolled on this certificate, enrolled on another Family Critical Illness Plan? ◯ YES ◯ NO

First Name: _____ **Middle Name:** _____

Last Name: _____ **Date of Birth:** (Under age 60) ____ DD ____ MM _____ YYYY **Sex:** ◯ Male ◯ Female

Identification: ◯ ID Card ◯ Driver's License ◯ Passport ◯ Birth Certificate **Proof of Address:** ◯ Utility Bill ◯ Other

Organization/Credit Union: _____ **Membership No.:** _____

Residential Address: _____

Mailing Address *(If different from above):* _____

Telephone: Home _____ **Work** _____ **Mobile** _____

Email Address: _____

SECTION II - Insured Information

	Primary Insured	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
Name (First)	NA					
Name (Middle)	NA					
Name (Surname)	NA					
Address	NA					
Proof of Address • Utility Bill • Registered Mail	NA	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
Date of Birth	NA					
Proof of Age • Passport • Identification Card • Driver's Permit • Birth Certificate	NA	◯ ◯ ◯ ◯	◯ ◯ ◯ ◯	◯ ◯ ◯ ◯	◯ ◯ ◯ ◯	◯ ◯ ◯ ◯
Gender • Male •Female	NA	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
Telephone	NA					
Email	NA					
Relationship to Primary Insured	NA					
Proof of Relationship	NA					
Have you ever been diagnosed with: *(Check all that apply)*	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
• Cancer	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
• Paralysis	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
• HIV	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
• Heart Attack	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
• Major Burns	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
• Heart Conditions	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
• Stroke	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
• Coma	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
• Diabetes	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯	◯ ◯
Within the last five years, have you been treated or been advised that you have any of the following conditions: Cancer, Heart Attack, Stroke, Paralysis OR Major Burns?	YES NO ◯ ◯ (If yes give details)	YES NO ◯ ◯ (If yes give details)	YES NO ◯ ◯ (If yes give details)	YES NO ◯ ◯ (If yes give details)	YES NO ◯ ◯ (If yes give details)	YES NO ◯ ◯ (If yes give details)

SECTION III Coverage options and Monthly Premium.
Insureds' coverage should be equal or less than the Primary Insured's coverage amount

Please use Coverage Options and Monthly Premium Table in SECTION II to determine the benefit amount and premium for each insured (Insureds must NOT yet be 60 yrs of age at date of enrolment, except Children who must NOT yet be 26 yrs of age at date of enrolment)

	Benefit $50,000.00		Benefit $100,000.00		Benefit $150,000.00		Benefit $200,000.00	
Age bands (Yrs)	**Primary Insured**	**Insureds**	**Primary Insured**	**Insureds**	**Primary Insured**	**Insureds**	**Primary Insured**	**Insureds**
<35	$ 36.50	$ 32.85	$ 73.00	$ 65.70	$ 109.50	$ 98.55	$ 146.00	$ 131.40
35-44	$ 75.00	$ 67.50	$ 150.00	$ 135.00	$ 225.00	$ 202.50	$ 300.00	$ 270.00
45-54	$ 157.00	$ 141.30	$ 314.00	$ 282.60	$ 471.00	$ 423.90	$ 628.00	$ 565.20
55-59	$ 236.50	$ 212.85	$ 473.00	$ 425.70	$ 709.50	$ 638.55	$ 946.00	$ 851.40

	Primary Insured	Insured 1	Insured 2	Insured 3	Insured 4	Insured 5
Benefit Option Amount						
Premium Due						

TOTAL PREMIUM WITH APPLICATION $_____

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BENEFIT INFORMATION

1. The monthly premium payable for all Insured Persons is based on the issue age and the selected coverage limit.
2. The maximum enrolment age for adults is 59 years up to and including day before the 60th birthday and 25 years in the case of the Primary Insured's children.
3. Termination age is 26 years from the Primary Insured's unmarried children who are not permanently disabled and 75 years for all other Insured Persons.
4. The premium amount payable for each coverage amount applied for remains the same for that coverage amount throughout the lifetime of the certificate for each Insured Person.**
5. The Primary Insured will be required to collect the benefit for all Insured Persons once alive and medically able to do so.
6. Benefits under this Policy are not payable if the diagnosis of a covered Critical Illness results either directly or indirectly from AIDS or HIV virus during the five years of continuous coverage immediately following the effective date of enrolment and subject to the definition of cancer as stated in the Policy contract.
7. We will not pay a benefit if an Insured Person is diagnosed with a Critical Illness caused either directly or indirectly from any disease, health condition or bodily injury for which the Insured Person received medical advice, consultation, diagnosis or treatment prior to the Effective Date of the Plan for the Insured Person and which disease, health condition or bodily injury was known to the Insured Person and/or the Primary Insured and was not fully and truthfully disclosed to us prior to the Effective Date of coverage.

DESIGNATION OF BENEFICIARY FOR THE PRIMARY INSURED – REVOCABLE

I hereby designate the following person as my Beneficiary for the Family Critical Illness Plan. My designated Beneficiary, if living, shall be the only person authorized to complete a claim form for me as the Primary Insured in the event that I am medically incapable of doing so upon certification by my attending specialist doctor, to collect on my behalf any and all sums of money, herein called the 'BENEFIT', payable to me under and by virtue of the terms and conditions of the Family Critical Illness Plan.

This designation replaces any earlier designation. I hereby reserve the right to change the Beneficiary herein designated. If the designated Beneficiary precedes me in death, or I do not designate a Beneficiary, the above payments will be paid in accordance with the priority stated in the Designation of Authorization in the Policy.

Name _____ **Age**_____ **Relationship**_____

Address _____ **Trustee's Name** _____
(If beneficiary is under 18)

Telephone Contact _____

PRIMARY INSUREDS' DECLARATION

I understand and certify that, to the best of my knowledge and belief, all statements contained in this enrolment form are true and agree that if there is any evasion, concealment, or misrepresentation in any of the statements made herein, the insurance issued on the basis hereof may be null and void or maybe adjusted based on true state of affairs. I also understand that where I am applying for coverage under The Family Critical Illness Plan (FCIP) that starting from the effective date of coverage, I will be subject to a six-month waiting period during which time only claims arising from the diagnosis of a covered critical illness resulting from an accident, will be paid.

I hereby authorize CUNA Caribbean Insurance Society Limited or its representative to obtain information and records from any physician or medical professional having information with respect to my physical or mental condition for the purpose of the Family Critical Illness Plan (including for processing any claim) and also specifically consent to such a physician or medical professional disclosing such information to CUNA Caribbean Insurance society Limited or its representative.

I hereby agree to receive notices and other information from CUNA Caribbean Insurance Society Limited.
I have read and understood the above information. In confirmation of this, I have signed and dated this document.

PRIMARY INSURED'S SIGNATURE _____ MM / DD / YY _____ / _____ / _____

ADDITIONAL INSUREDS' DECLARATION (To be completed by all additional enrolees over the age of 18 years)

I acknowledge that this Plan has been issued based on the information provided in The Family Critical Illness Plan Enrolment Form for insurance. I confirm that I have read carefully and given _____ (Primary Insured) authorization to apply for coverage on my behalf. I understand that:

- If, I am no longer interested in the insurance and elect to cancel this policy, I must submit a written request to terminate my coverage.
- I am being enrolled for the Family Critical Illness Plan coverage and therefore will be subject to a six months waiting period during which **no claim** is payable on diagnosis of a covered critical illness other than one directly resulting from an accident.
- The Order of Payment and Designation of Authorization as outlined in Policy dictates the payment of benefit and refund.

I hereby authorize and consent to the Primary Insured submitting medical reports in relation to me to CUNA Caribbean Insurance Society Ltd upon a claim being made and collecting the benefit of said claim on my behalf. **I also acknowledge that I have read and understood the information stated under the Primary Insured Declaration above. In confirmation of this, I have signed and dated this document.**

NAME _____ SIGNATURE _____ MM / DD / YY _____ / _____ / _____

NAME _____ SIGNATURE _____ MM / DD / YY _____ / _____ / _____

NAME _____ SIGNATURE _____ MM / DD / YY _____ / _____ / _____

NAME _____ SIGNATURE _____ MM / DD / YY _____ / _____ / _____

NAME _____ SIGNATURE _____ MM / DD / YY _____ / _____ / _____

Enrolment Taken By _____ PRINT NAME OF STAFF _____ Date _____ / _____ / _____
MM / DD / YY

Place Company Stamp here:

**Premium rates are subject to change. All Benefits and Provisions are subject to the Terms and Conditions of the Policy which is available at your institution. Insurance coverage is subject to approval by CUNA Caribbean Insurance Society Limited (CCISL). Insurance coverage is not enforced until a certificate has been issued by CCISL.

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