THE FAMILY INDEMNITY PLAN

CUNA CARIBBEAN INSURANCE

MEMBER ENROLLMENT FORM

PLEASE WRITE CLEARLY: Indicate your complete name, date of birth, age and the relationship of all individuals enrolling in the plan including yourself

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH DAY / MONTH / YEAR			AGE	SEX	RELATIONSHIP TO MEMBER
1.								MEMBER
2.								
3.								
4.								
5.								
6.								

We reserve the right to request proof of the above information.

My membership No. _____ **Name of Institution** _____

My complete address _____ **My Telephone No.** _____ **Email** _____

Indicate the plan selected**:** ☐**Plan A** ($80,000.00) ☐**Plan B** ($120,000.00) ☐**Plan C** ($150,000.00) ☐**Plan D** ($250,000.00) ☐**Plan E** ($400,000.00) ☐**Plan F** $650,000.00)

1. Are you or any person named above presently covered under another Family Indemnity Plan? ☐Yes ☐No
2. Have you previously had a Family Indemnity Plan certificate? ☐Yes ☐No

It is the sole responsibility of the Member to ensure that eligible persons for whom application is being made are not persons who have existing coverage under The Family Indemnity Plan at any other Institution. No person(s) may be insured through more than one Family Indemnity Plan Certificate in accordance with the Non-Duplication of Coverage clause contained in the Policy and the Member's Family Indemnity Plan Certificate. If a person is named under more than one Family Indemnity Plan Certificate, on the death of such a person, the Insurer shall only be liable to pay <u>one</u> claim.

I understand that I am enrolling for the Family Indemnity Plan coverage and therefore will be subject to a six months waiting period during which **<u>no claim</u>** is payable for death which occurs as a result of natural causes. During the six months waiting period only accidental death benefits will be paid.

I fully understand that the effective date of the certificate will always be the first of the month following enrollment. The waiting period is always six months from the effective date of coverage.

I understand and certify that, to the best of my knowledge and belief, all statements contained in this enrollment 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 shall be null and void.

I have read and understood the above information. In confirmation of this, I have signed and dated this document.

PLEASE COMPLETE A DESIGNATION OF BENEFICIARY FORM IF YOU ARE THE ONLY INSURED PERSON.

Enrollment Taken By: _____ _____ **DATE** _____/_____/_____

PRINT NAME OF STAFF **MEMBER'S SIGNATURE** **DD / MM / YY**

***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.**