RESET

THE FAMILY INDEMNITY PLAN - GROUP CHANGE OF PLAN/COVERAGE FORM

CUNA CARIBBEAN INSURANCE JAMAICA LTD.

Select the option(s) that apply: ☑ THE FAMILY INDEMNITY PLAN ☐ CRITICAL ILLNESS RIDER

SECTION 1: PRIMARY INSURED INFORMATION

FIRST NAME | MIDDLE NAME | LAST NAME

DATE OF BIRTH (dd/mm/yyyy) | GENDER (M / F) | TRN NO. | ID TYPE & NO.

MOBILE NO. | OTHER TELEPHONE NO. | EMAIL ADDRESS

ADDRESS

PARISH/ CITY/STATE | COUNTRY OF BIRTH | COUNTRY OF RESIDENCE

OCCUPATION | SOURCE OF FUNDS | ACCOUNT #

ADMINISTRATOR | BRANCH | PLAN NO.

ADDITIONAL DUE DILIGENCE AND TAX RESIDENCY INFORMATION

1. Are you, or any of your immediate family[1] members or close associates, currently or have been within the last five years, a PEP* either locally or internationally? Yes ☐ No ☐
2. Details of Associated PEP (If applicable) - If you have indicated that you are a PEP or are associated with one, please provide the following details: Yes ☐ No ☐
   a. Full Name of PEP:
   b. Job Title/Position of PEP:
   c. Nature of relationship to PEP (if not yourself):
3. Do you hold citizenship/ nationality/ residency status or are required to file taxes in another country/ countries: Yes ☐ No ☐
4. Have you granted a U.S. person the authority, under a power of attorney, or signatory Authority for this policy to individuals who are U.S. citizens/residents or holders of U.S. Address? Yes ☐ No ☐

If your answer is yes to questions 3 or 4 above, please complete the Tax Residency Self Certification form. If your answer is 'No', please sign the applicant's declaration below.

PRIMARY INSURED'S DECLARATION

I, _____ ,declare that I am not a citizen or tax resident of any country other than those listed on this form or the Tax Residency Self-Certification Form. I shall inform CUNA Caribbean Insurance Jamaica Limited no later than sixty (60) days of any changes to the information provided in this form. I understand that I may be required to submit additional documentation to verify my tax status before a policy can be issued.

Signature of Primary Insured: _____ Date: _____ (dd/mm/yyyy)

***PEP – Politically Exposed Persons refer to a prominent public function/position entrusted to individuals e.g. current or former Heads of State or of government, Ministers of Government, senior governmental, judicial, or military officials, senior executives of state-owned corporations, senior members of a political party.**

[1]Immediate family members include Spouse/Ex-spouse, parent, child/stepchild, sibling/half-sibling

NB: If you responded "Yes" to any of the questions above we will contact you to obtain additional information necessary to complete your application.

NB: A COPY OF YOUR PICTURE IDENTIFICATION (NATIONAL ID, DRIVERS PERMIT, PASSPORT), TRN, PROOF OF ADDRESS (E.G. UTILITY BILL OR BANK STATEMENT NOT OLDER THAN 3 MONTHS) AND THE PREMIUM(S) TO COMPLETE THIS CHANGE, MUST BE SUBMITTED WITH THIS COVERAGE CHANGE REQUEST. IF REQUIRED DOCUMENTS ARE NOT SUBMITTED, THE REQUEST WILL BE PLACED ON HOLD AND THE CHANGE WILL NOT BE EFFECTED. WE MAY REQUEST ADDITIONAL DOCUMENTATION, IF NECESSARY, BEFORE COMPLETING THIS REQUEST.

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SECTION 2: Please complete the section below if you are applying for a CHANGE OF PLAN for your FAMILY INDEMNITY PLAN:

THE FAMILY INDEMNITY PLAN

Current Plan:	A ☐	B ☐	C ☐	D ☐	E ☐	F ☐

Select your NEW Plan from the listed options:

PLAN TYPE	INDIVIDUAL BENEFIT	MONTHLY PREMIUM
B ☐	$120,000	$633.60
C ☐	$150,000	$792.00
D ☐	$250,000	$1,320.00
E ☐	$400,000	$2,112.00
F ☐	$650,000	$3,432.00
G ☐	$1,000,000	$5,280.00

SECTION 3: Please complete the section below if you are applying for CHANGE OF COVERAGE for your CRITICAL ILLNESS RIDER

Select your NEW coverage from the listed options based on your current age.

CRITICAL ILLNESS RIDER – Select the Coverage option of your choice based on your current age			
CRITICAL ILLNESS RIDER COVERAGE OPTIONS		Coverage: $ 500,000.00	Coverage: $ 1,000,000.00
AGE BAND	18-29	$145.00 ☐	$290.00 ☐
	30-34	$155.00 ☐	$310.00 ☐
	35-39	$210.00 ☐	$420.00 ☐
	40-44	$355.00 ☐	$710.00 ☐
	45-49	$590.00 ☐	$1,180.00 ☐
	50-55	$1,040.00 ☐	$2,080.00 ☐
	56-60	$1,250.00 ☐	$2,500.00 ☐
	61-65	$1,500.00 ☐	$3,000.00 ☐
	66-70	$2,500.00 ☐	$5,000.00 ☐
	71-74	$3,500.00 ☐	$7,000.00 ☐

1. Have you ever been diagnosed with any of the following: cancer, heart disease of any kind, stroke, paralysis or major burns? Yes ☐ No ☐

   1b. If yes, please indicate the details

2. Have you received, in the last 5 years, any medical attention, medical advice, surgical treatment or have been prescribed medication for any of the following conditions: cancer, heart disease of any kind, stroke, paralysis or major burns? Yes ☐ No ☐

   2b. If yes, please indicate the details

TERMS AND CONDITIONS OF SERVICE

All Benefits and Provisions are subject to the Terms and Conditions of the Family Indemnity Plan (FIP) Policy and/or Critical Illness Rider that was issued to You.

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SECTION 4: DECLARATION & DATA PROTECTION

I understand that the **Effective Date of Coverage**, on the approved **Change of Plan** endorsement letter, will always be the first day of the month following the signed date indicated on this form.

I also understand that where I am applying for a **Change of Plan** under the **Family Indemnity Plan (FIP)** and that starting from the effective date of coverage, in the event of a change to a higher Plan, **a six (6) month waiting period** applies. If death occurs during the six-month waiting period, Benefits will be paid based on the lower Plan. However, where the death of an Insured Person occurs as a result of an accident during the six (6) month waiting period, the Benefit will be paid based on the higher Plan.

In the event of a change to a lower Plan (where applicable), Benefits based on the lower Plan become effective on the first of the month following the date on which the application was made for the change.

I also understand that where I am applying for a Change of Plan under the FIP Critical Illness Rider that starting from the effective date of coverage, I will be subject to **a six (6) month waiting period**, during which time only critical illness claims arising as a direct result of an accident and immediately following the effective date of my application, will be paid at the higher coverage amount, and; where critical illness claims arise due to natural causes and immediately following the effective date of my application, the benefit will be paid at the lower coverage amount. In the event of a change to lower coverage (where applicable), Benefits based on the lower coverage become effective on the first of the month following the date on which the application was made for the change.

DATA PROTECTION

CUNA Caribbean Insurance Jamaica Limited is committed to the protection of your Personal Data, as defined under applicable laws, which is collected, used and otherwise processed by us in accordance with the Data Protection Act, as outlined in our Privacy Notice, which can be obtained from our website at www.cunacaribbean.com or at any of our locations or at the offices of your administrators, insurance brokers or agent. We reserve the right to update our Privacy Notice from time to time and same shall be available to you in the manner previously mentioned. The consents that we require to process your data are outlined below. Please review them carefully and if you agree, place a tick in the appropriate boxes, and sign at the space provided in acknowledgement of your agreement. If you do NOT agree with the "Mandatory" consents required to process the information provided on this application, please do NOT submit this application and destroy it to ensure the protection of the personal information contained herein.

MANDATORY CONSENT TO PROCESS DATA:

I hereby give my explicit consent for the collection, processing, use, and sharing of my personal data, including but not limited to my health data, and to the collection, processing, use and sharing of the personal data, including but not limited to the health data, of my dependents (being a minor, mental health patient or anyone of whom I am otherwise a legal representative), as is necessary for and pertaining to my or my dependent's insurance coverage, evaluation, payment of benefits and other matters related thereto by CUNA Caribbean Insurance Jamaica Limited, and where applicable the Administrator, for the purpose of risk assessment, underwriting, servicing my policy, claims processing, compliance with legislative obligations under any law and for purposes of fraud prevention. I understand that this includes sharing my personal data with the regulatory authorities, reinsurers, and other third parties as required by law, as necessary for the administering of my policy or fraud prevention.

OPTIONAL CONSENT:

I agree to receive direct communication from CCIJ via written notice, SMS, email, etc. in relation to other products and services which may be offered by the company. Yes ☐ No ☐

By signing this document, I confirm that I have read and understood the above information and provide consent where applicable.

Signature of Primary Insured: _____ Date: _____
dd/mm/yyyy

FOR OFFICIAL USE ONLY. To be completed by the Administrator

Application taken by: _____
Please Print Name

Date _____
dd/mm/yyyy