RESET

CUNA CARIBBEAN INSURANCE JAMAICA LTD.

THE FAMILY CRITICAL ILLNESS PLAN ENROLLMENT FORM

SECTION I- Primary Insured's Information

1. Have you previously had a Family Critical Illness Plan? ○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:** ____ DD ____ MM ____ YYYY (Under age 60) **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: ____________________
Street *City* *Country* *Zip Code*

Mailing Address *(If different from above):* ____________________
Street *City* *Country* *Zip Code*

Telephone: Home: ____________________ **Work:** ____________________ **Mobile:** ____________________

Email Address: ____________________ **Certificate No.:** ____________________

SECTION II- Insured's Information

Please use Coverage Options and Monthly Premium in Section III to determine the benefit amount and premium for each insured (Insured must NOT yet be 60 years of age at date of enrolment, except Children who must NOT yet be 26 years of age at date of enrolment)

	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 License • Birth Certificate	NA	○ ○ ○ ○	○ ○ ○ ○	○ ○ ○ ○	○ ○ ○ ○	○ ○ ○ ○
Gender • Male • Female	NA	○ ○	○ ○	○ ○	○ ○	○ ○
Telephone	NA					
Email	NA					
Relationship to Primary Insured	NA	Select	Select	Select	Select	Select
Have you ever been diagnosed with? (Check all that apply) • Cancer • Paralysis • HIV • Heart Attack • Major Burns • Stroke • Coma • Diabetes	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
Within the last five years, have you been treated or been advised that you have any of the following conditions: *Cancer, Stroke, Heart Attack, Major Burns, Paralysis or Coma?*	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

	Benefit $500,000		Benefit $1,000,000		Benefit $1,500,000		Benefit $2,000,000		Benefit $2,500,000	
Age bands	Primary Insured	Insureds	Primary Insured	Insureds	Primary Insured	Insureds	Primary Insured	Insureds	Primary Insured	Insureds
<35	$ 365	$ 328.50	$ 730	$ 657	$ 1,095	$ 985.50	$ 1,460	$ 1,314	$ 1,825	$ 1,642.50
35-44	$ 750	$ 675	$ 1,500	$ 1,350	$ 2,250	$ 2,025	$ 3,000	$ 2,700	$ 3,750	$ 3,375
45-54	$ 1,570	$ 1,413	$ 3,140	$ 2,826	$ 4,710	$ 4,239	$ 6,280	$ 5,652	$ 7,850	$ 7,065
55-59	$ 2,365	$ 2,128.50	$ 4,730	$ 4,257	$ 7,095	$ 6,385.50	$ 9,460	$ 8,514	$ 11,825	$ 10,642.50

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

TOTAL PREMIUM WITH APPLICATION $____________________

CCIJ-FCIP-PIE-02181

A member of CUNA MUTUAL GROUP

CUNA CARIBBEAN INSURANCE JAMAICA LTD.

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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 Persons.
3. Termination age is 26 years from the Primary Insured's unmarried children who are not permanently disables 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 I**ll**ness 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 **C**ritical I**ll**ness caused either directly 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 **C**ritical I**ll**ness 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 co**ll**ect 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 **C**ritical I**ll**ness 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 of the Policy.

Name_____ **Age**_____ **Relationship**_____

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

Telephone Contact_____

PRIMARY INSURED'S DECLARATION

I understand and certify that, to the best of my knowledge and belief, all statements contained in this enrolment 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 nu**ll** and void or maybe adjusted based on true state of affairs. I hereby agree to receive notices and other information from CUNA Caribbean Insurance Jamaica Ltd.

I hereby authorize CUNA Caribbean Insurance Jamaica Ltd or its representative to obtain information and records from any physician or medical professional having information with respect to my physical or mental condition of the purpose of the Family **C**ritical I**ll**ness Plan (including for processing any claim) and also specifically consent to such physician or medical professional disclosing such information to CUNA Caribbean Insurance Jamaica Limited or its representative.

I hereby agree to receive notices and other information from CUNA Caribbean Insurance Jamaica Limited.
I have read and understood the above information. In confirmation to 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 **C**ritical I**ll**ness Plan Enrolment Form for insurance. I confirm that I have read carefully and given _____ (**P**rimary 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 **C**ritical I**ll**ness 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 **P**ayment and **D**esignation of Authorization as outlined in **P**olicy dictates the payment of benefit and refund.

I hereby authorize and consent to the Primary **I**nsured submitting medical reports in relation to me to CUNA Caribbean Insurance Jamaica 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**_____

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 Jamaica Limited (CCIJ). Insurance coverage is not enforced until a certificate has been issued by CCIJ.