

# COVID-19 RELIEF FUND APPLICATION FORM



*This application is being made for temporary FIP premium relief for the Primary Insured Member who has become unemployed as a result of COVID-19.*

Family Indemnity Plan Certificate No: \_\_\_\_\_

Plan Type                                    **A**    **B**    **C**    **D**    **E**    **F**    **G**

First Name                                    \_\_\_\_\_

Last Name                                    \_\_\_\_\_

Address                                        \_\_\_\_\_  
\_\_\_\_\_

Mailing address, if different            \_\_\_\_\_  
\_\_\_\_\_

E-mail address                              \_\_\_\_\_

Mobile Number                              \_\_\_\_\_

Choose Identification                      ID                         DP                         PP  

Identification Number                      \_\_\_\_\_

Where is your Family Indemnity Plan  
Certificate held?                              ORGANISATION: \_\_\_\_\_  
BRANCH: \_\_\_\_\_

## Please respond to the following:

### A. EMPLOYED *(Person employed for wages or salary)*

Have you become unemployed as a result of COVID-19 after March 31, 2020?

YES                         NO  

Employer's Name                              \_\_\_\_\_

Last Date of Work                              \_\_\_\_\_  
*(dd/mm/yyyy)*

### B. SELF-EMPLOYED *(Person in business for themselves)*

Has your business closed as a result of COVID-19 after March 31, 2020?

YES                         NO  

Name of Business                              \_\_\_\_\_

Last Date of Operation                      \_\_\_\_\_  
*(dd/mm/yyyy)*

- I acknowledge and agree that this will be a onetime benefit, applicable for six (6) consecutive months **only**.
- I acknowledge and agree that if my premiums are not paid after this relief period has ended in accordance with the terms and conditions of the FIP certificate issued to me, coverage will be terminated as outlined in the FIP policy held by the Organisation.
- I understand and certify that, to the best of my knowledge and belief, all information provided is true and correct.**

\_\_\_\_\_  
**Signature**  
**(Certificate Owner)**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**  
*(dd/mm/yyyy)*

\_\_\_\_\_  
**Signature**  
**(Authorised Organisation Officer)**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Date**  
*(dd/mm/yyyy)*

**COVID-19 RELIEF FUND  
APPLICATION FORM**



**FOR OFFICIAL USE ONLY. To be completed by the Organisation**

**Completed Application Form?** YES  NO

**Certified copy of letter from former employer confirming termination due to COVID-19?** YES  NO

**Certified copy of affidavit\* attesting to unemployment due to COVID-19?** YES  NO

*\* Applicable to self-employed persons or informal workers with no access to job letters.*

Affidavits for **Informally Employed Individuals** must include:

1. The Role
2. Name of Former Employer
3. Former Employer's address
4. Former Employer's telephone number
5. Length of employment
6. Date of termination due to COVID-19

Affidavits for **Self-Employed Individuals** must include:

1. Name of Former Business, if applicable
2. Registered address, if applicable
3. Business telephone number
4. Length of time business was in operation
5. Date when business ceased operations due to COVID-19

**Certified copy of valid identification?** YES  NO

**Certified copy of proof of address, not older than three (3) months?** YES  NO

**FOR OFFICIAL USE ONLY. To be completed by CUNA Caribbean Insurance**

**RECOMMENDED FOR APPROVAL:** YES  NO

\_\_\_\_\_  
Signature  
(Authorised Officer)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date  
(dd/mm/yyyy)

**APPROVED** YES  NO

\_\_\_\_\_  
Signature  
(Authorised Officer)

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date  
(dd/mm/yyyy)