COVID-19 RELIEF FUND APPLICATION FORM

CUNA CARIBBEAN INSURANCE

This application is being made for temporary FIP premium relief for the Primary Insured Member, or Spouse/Significant Other on the certificate, who has become unemployed as a result of COVID-19.

PRIMARY INSURED

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: _____

SPOUSE/SIGNIFICANT OTHER

First Name _____

Last Name _____

Address _____

_____

Mailing address, if different _____

_____

E-mail address _____

Mobile Number _____

Choose Identification ID ○ DP ○ PP ○

Identification Number _____

Please respond to the following:

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

Have you, or your spouse /significant other, 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, or your spouse/significant other, closed as a result of COVID-19 after March 31, 2020? YES ○ NO ○

Name of Business _____

Last Date of Operation _____

(dd/mm/yyyy)

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- ○ 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 (Spouse/Significant Other)	**Print Name**	**Date** ***(dd/mm/yyyy)***
_____	_____	_____
Signature (Authorised Organisation Officer)	**Print Name**	**Date** ***(dd/mm/yyyy)***

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 for Primary Insured, or Spouse/Significant Other?	**YES**	○	**NO**	○	
Certified copy of affidavit* attesting to unemployment due to COVID-19 for Primary Insured, or Spouse/Significant Other?	**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 for Primary Insured, or Spouse/Significant Other?	**YES**	○	**NO**	○	
Certified copy of proof of address for Primary Insured, not older than three (3) months?	**YES**	○	**NO**	○	

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RECOMMENDED FOR APPROVAL:	**YES**	○	**NO**	○	

_____	_____	_____
Signature (Authorised Officer)	**Print Name**	**Date** ***(dd/mm/yyyy)***

APPROVED	**YES**	○	**NO**	○	