The Family Critical Illness Plan
PRIMARY INSURED'S ENROLMENT FORM

Please write in BLOCK letters, mark all choice boxes with and 'X'
Applicant must complete all sections.

CUNA CARIBBEAN INSURANCE

	YES	NO
1. Have you previously had a Family Critical Illness Plan certificate?	[ ]	[ ]
2. Are you or any person(s) who will be enrolled on this certificate, enrolled on another Family Critical Illness Plan?	[ ]	[ ]

First Name **Middle Name** **Last Name**

Date of Birth: D D M M Y Y Y Y **Membership No.:** **Sex:** Male [ ] Female [ ]

Proof of Age Submitted:
Birth Certificate [ ] Driver's License [ ] Passport [ ] ID Card [ ]

Proof of Address Submitted:
Utility Bill [ ] Registered Mail [ ]

Organization: ____________________

Residential Address: ____________________
Street *City* *Country* *Zip Code*

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

Telephone: (Home) - - **(Work)** - - **(Mobile)**

Email address:

Please answer the following questions.

1a. Have you ever been treated or diagnosed with (*Check all that apply*):

Cancer	[ ]	Heart Attack	[ ]	Stroke	[ ]
Paralysis,	[ ]	Major Burns	[ ]	Coma	[ ]
HIV	[ ]	Heart Conditions	[ ]	Diabetes	[ ]

2a. Have you received, in the last five (5) years, any medical attention or advice or surgical treatment or been hospitalized? [ ]

2b. If yes, please indicate the details ____________________

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Benefits under this Policy are not payable if the diagnosis of a Critical Illness covered results either directly or indirectly from AIDS or HIV virus during the five years of continuous coverage immediately following the effective date of enrolment

We will not pay a benefit if an Insured Person is diagnosed with a Critical Illness caused either directly or indirectly 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.

Please indicate the MONTHLY PREMIUM that corresponds with your AGE and COVERAGE LIMIT:

Coverage Option – Primary Insured					**Monthly Premium Per Person**			
Age Band (Yrs)	$50,000		$100,000		$150,000		$200,000	
<35	☐	$36.50	☐	$73.00	☐	$109.50	☐	$146.00
35-44	☐	$75.00	☐	$150.00	☐	$225.00	☐	$300.00
45-54	☐	$157.00	☐	$314.00	☐	$471.00	☐	$628.00
55-59	☐	$236.50	☐	$473.00	☐	$709.50	☐	$946.00

Amount Due: . Date Paid: D D M M Y Y Y Y

BENEFIT INFORMATION

1. The monthly premium payable for the Primary Insured is based on the issue age and the selected coverage limit.
2. The maximum enrollment 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's children.
3. Termination age is 26 years for the Primary Insured's unmarried children who are not permanently disabled 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.

PRIMARY INSURED'S SIGNATURE____________________ **MM / DD / YY** ______/_______/________

DESIGNATION OF Beneficiary for the Primary Insured - REVOCABLE

I hereby designate the following person as my Beneficiary for the Family Critical Illness 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 collect 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 Critical Illness 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 if I do not designate a Beneficiary, the above payments will be paid in accordance with the priority stated in the Designation of Authorization in the Policy.

Name ____________________ **Age** ____________ **Relationship** ______________ **(If under 18 years, please indicate Trustee's Name:** ____________________

Address ____________________

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 maybe be null and void or maybe adjusted based on true state of affairs. I hereby agree to receive notices and other information from CUNA Caribbean Insurance Society Limited.

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

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

Enrolment Taken By: ____________________ PRINT NAME OF STAFF ____________________ DATE ______/_______/________

PRIMARY INSURED'S SIGNATURE____________________ MM / DD / 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. Insurance coverage is subject to approval by CUNA Caribbean Insurance Society Limited (CCISL). Insurance coverage is not enforced until a certificate has been issued by CCISL.**