

THE FAMILY INDEMNITY PLAN APPLICATION FORM (WITH OPTIONAL CRITICAL ILLNESS RIDER)

SECTION 1: APPLICANT INFORMATION

FIRST NAME <input style="width:95%;" type="text"/>	MIDDLE NAME <input style="width:95%;" type="text"/>	LAST NAME <input style="width:95%;" type="text"/>
DATE OF BIRTH <input style="width:95%;" type="text"/> <small>dd/mm/yyyy</small>	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	TRN NO. <input style="width:95%;" type="text"/>
MOBILE NO. <input style="width:95%;" type="text"/>	OTHER TELEPHONE NO. <input style="width:95%;" type="text"/>	ID TYPE & NO. <input style="width:95%;" type="text"/>
EMAIL ADDRESS <input style="width:95%;" type="text"/>		
ADDRESS <input style="width:95%;" type="text"/>		
PARISH/ CITY/STATE <input style="width:95%;" type="text"/>	COUNTRY OF BIRTH <input style="width:95%;" type="text"/>	COUNTRY OF RESIDENCE <input style="width:95%;" type="text"/>
OCCUPATION <input style="width:95%;" type="text"/>	SOURCE OF FUNDS <input style="width:95%;" type="text"/>	ACCOUNT # <input style="width:95%;" type="text"/>
ADMINISTRATOR <input style="width:95%;" type="text"/>	BRANCH <input style="width:95%;" type="text"/>	

ADDITIONAL DUE DILIGENCE AND TAX RESIDENCY INFORMATION

1. Are you, or any of your immediate family¹ 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.

APPLICANT'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 (CCIJ) 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 Applicant: _____

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.**

¹Immediate 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 PICTURE IDENTIFICATION (NATIONAL ID, DRIVERS PERMIT, PASSPORT), PROOF OF ADDRESS (E.G. UTILITY BILL OR BANK STATEMENT NOT OLDER THAN 3 MONTHS) AND THE FIRST MONTH'S PREMIUM MUST BE SUBMITTED WITH THIS APPLICATION. IF REQUIRED DOCUMENTS ARE NOT SUBMITTED APPLICATION WILL BE PLACED ON HOLD AND NO COVERAGE WILL BE EFFECTED. WE MAY REQUEST ADDITIONAL DOCUMENTATION, IF NECESSARY, BEFORE ISSUING YOUR POLICY.

SECTION 2: SELECT THE PLAN OF YOUR CHOICE FROM THE COVERAGE OPTIONS. PREMIUM AND COVERAGE AMOUNT IS LISTED NEXT TO THE CORRESPONDING PLAN:

PLAN TYPE	INDIVIDUAL BENEFIT	MONTHLY PREMIUM
A <input type="checkbox"/>	\$80,000	\$422.40
B <input type="checkbox"/>	\$120,000	\$633.60
C <input type="checkbox"/>	\$150,000	\$792.00
D <input type="checkbox"/>	\$250,000	\$1,320.00
E <input type="checkbox"/>	\$400,000	\$2,112.00
F <input type="checkbox"/>	\$650,000	\$3,432.00

PLAN TYPE	INDIVIDUAL BENEFIT	MONTHLY PREMIUM
G <input type="checkbox"/>	\$1,000,000	\$5,280.00
H <input type="checkbox"/>	\$1,300,000	\$6,864.00
I <input type="checkbox"/>	\$1,600,000	\$8,864.00
J <input type="checkbox"/>	\$1,800,000	\$10,458.00
K <input type="checkbox"/>	\$2,000,000	\$12,680.00

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PLEASE COMPLETE THE SECTION BELOW ONLY IF YOU ARE APPLYING FOR THE CRITICAL ILLNESS RIDER

CRITICAL ILLNESS RIDER – Select the Coverage option of your choice based on your current age					
CRITICAL ILLNESS RIDER COVERAGE OPTIONS		Age Band			
		18-34	35-44	45-54	55-59
MONTHLY PREMIUM	Option 1: \$ 500,000.00	\$350.00 <input type="checkbox"/>	\$715.00 <input type="checkbox"/>	\$1,490.00 <input type="checkbox"/>	\$2,245.00 <input type="checkbox"/>
	Option 2: \$ 1,000,000.00	\$700.00 <input type="checkbox"/>	\$1,430.00 <input type="checkbox"/>	\$2,980.00 <input type="checkbox"/>	\$4,490.00 <input type="checkbox"/>

- 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
- 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

SECTION 3: ADDITIONAL PROPOSED INSURED(S) INFORMATION: PLEASE ENSURE ALL INFORMATION IS COMPLETED

ONLY CHILDREN UNDER THE AGE OF EIGHTEEN (18) ARE TO BE INCLUDED IN THIS SECTION. Coverage is not automatic and is subject to approval by CUNA Caribbean Insurance Jamaica Limited (CCIJ). Persons approved for coverage will be listed on the Policy issued by CCIJ to the Applicant.

This section is to be completed in entirety. Enter names of additional persons.		IDENTIFICATION ID = National ID DP = Drivers Permit PP = Passport BC = Birth Certificate	
1	<input type="text"/>	ID <input type="checkbox"/>	DP <input type="checkbox"/>
CHILD	DATE OF BIRTH dd/mm/yyyy <input type="text"/> GENDER M <input type="checkbox"/> F <input type="checkbox"/>	PP <input type="checkbox"/>	BC <input type="checkbox"/>
2	<input type="text"/>	ID <input type="checkbox"/>	DP <input type="checkbox"/>
CHILD	DATE OF BIRTH dd/mm/yyyy <input type="text"/> GENDER M <input type="checkbox"/> F <input type="checkbox"/>	PP <input type="checkbox"/>	BC <input type="checkbox"/>
3	<input type="text"/>	ID <input type="checkbox"/>	DP <input type="checkbox"/>
CHILD	DATE OF BIRTH dd/mm/yyyy <input type="text"/> GENDER M <input type="checkbox"/> F <input type="checkbox"/>	PP <input type="checkbox"/>	BC <input type="checkbox"/>

DESIGNATION OF BENEFICIARY FOR THE APPLICANT

I hereby designate the following person as my Beneficiary for Family Indemnity Plan. My Beneficiary, if living, shall receive any and all sums of money, herein called the 'BENEFIT', paid under and by virtue of the terms and conditions of the Family Indemnity Plan, of the CUNA Caribbean Insurance Jamaica to the said Organization.

This designation takes precedence over any earlier designation wherever and however made. I hereby reserve the right to change the Beneficiary herein designated. If the designated beneficiary precedes me in death, the Benefit will be paid to my Estate

(Use given name. Example: Helen Smith)

FIRST NAME MIDDLE NAME LAST NAME

AGE RELATIONSHIP CONTACT #

ADDRESS

If under 18, Please indicate Trustee's Name

Proportion: 100% Other

I hereby authorize any physician or medical professional having information with respect to my physical or mental condition to furnish such information to CUNA Caribbean Insurance Jamaica Limited or its representative.

Signature of Applicant: _____

Date: _____
dd/mm/yyyy

IF YOU WISH TO ADD ADDITIONAL BENEFICIARIES, PLEASE COMPLETE A DESIGNATION OF BENEFICIARY FORM.

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SECTION 4: DECLARATION & DATA PROTECTION

DECLARATION:

I understand that no person may be covered under more than one Policy issued by CUNA Caribbean Insurance Jamaica Limited (CCIJ), and I have verified that all persons listed on this form, to the best of their and my knowledge, are not covered under any other Policy.

I understand that I am applying for coverage under the Family Indemnity Plan and that coverage for persons listed on this application is not automatic and is subject to acceptance and approval of my application by CCIJ. Approval, if granted, will be communicated to me and a Policy bearing the full terms and conditions will be issued by CCIJ. Waiting period(s) will be stated on the Policy, during which no claim is payable for a loss which occurs as a result of natural causes.

I understand that where I have applied for coverage under the CRITICAL ILLNESS RIDER, there will be a waiting period for the Critical Illness Rider benefit which will be stated on the Policy. Further I understand that if a claim is made under the Critical Illness Rider and a diagnosis is confirmed during the waiting period, no benefit will be payable for that critical illness, unless that critical illness was a direct result of an accident immediately following the effective date stated on the Policy.

I understand that if insurance is approved for additional persons listed herein that Benefits will be paid to me as the Policyholder. I agree that should I, the Policyholder, predecease the other insureds listed in the Policy of insurance that benefits will be paid in the following order. To the designated beneficiary, if any; if no beneficiary is designated, to the spouse or significant other; if no spouse or significant other is listed, to the Policyholder's Parents equally, if no Policyholder's Parents listed, to the parents (equally) of the Policyholder's spouse or significant other if any; or, if the Policyholder's parents and the parents of the Policyholder's spouse or significant other are not Insured Persons under this policy to one parent of the Policyholder and one parent of the Policyholder's spouse or significant other, if any; or, to the unmarried insured dependent children and to the unmarried insured dependent children under legal guardianship of the Policyholder (equally), if any, or to their legal guardian to be held for the children's benefit should the children not meet the legal age requirements; or to the Policyholder's estate.

I agree to be bound by the terms and conditions of the Family Indemnity Plan and continued payment of premiums to CCIJ and acceptance thereof constitutes my ongoing agreement.

I understand and certify that, to the best of my knowledge and belief, all statements contained in this application 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 shall be null and void.

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 Applicant: _____

Date: _____
dd/mm/yyyy

FOR OFFICIAL USE ONLY. To be completed by the Administrator

Application taken by:

Please Print Name

Date: _____

dd/mm/yyyy

SECTION 5: ABOUT THE FAMILY INDEMNITY PLAN

Description of Plan

- You can choose any Plan from the Coverage Options.
- One monthly premium covers you and up to a maximum of five (5) eligible family Members
- No medical examination is required for coverage.
- Coverage ceases for Dependents on the plan once they attain age 26 or upon becoming married, whichever is first in time.
- Permanently disabled children, who are not married, can obtain lifetime coverage once they are fully dependent on you for support.
- Optional Critical Illness coverage is available for the Applicant only at an additional cost
- No duplication of coverage is allowed under the plan.
- Standard Waiting Periods must elapse before a Benefit becomes payable under any of the coverage options

Who is covered under the Family Indemnity Plan?

The plan you select can cover you and any combination of the following persons:

- Your spouse/co-habitant or any combination of up to two persons from your parents or parents-in-law (these persons must be under the age of 76 at the time of application)
- Children (biological, adopted, children under your legal guardianship and dependents with proven insurable interest, aged 0 through 25 and who are not yet married)
- Children who are permanently disabled are covered for the duration of their lives once they are approved for coverage before age 26. Medical report must be submitted to verify permanent disability.

What are the Family Indemnity Plan exclusions?

Benefits under the Family Indemnity Plan are not payable if the death occurs as a result of the following:

- 1) Suicide, committed within twenty-four (24) months of the effective date of the Policy or plan change.
- 2) Committing or attempting to commit a crime or any involvement in criminal activity.
- 3) A self-inflicted injury or illness, whether the Insured is sane or insane;
- 4) Injuries received by the Insured during his participation or engagement in a riot;
- 5) Alcohol dependency, drug addiction or any mental condition or mental disorder which resulted from alcohol dependency or drug addiction.

How does the Critical Illness Rider Work?

- The CI Rider is available in addition to any plan indicated on the form. There are two (2) coverage options available under the CI Rider and Premiums specified for benefit forms part of the monthly premium payments under the Family Indemnity Plan. The CI Rider is only available to the Applicant, who has not yet attained the age of sixty (60) at the time of application for the CI Rider.
- Coverage under the CI Rider will automatically terminate when the Applicant attains age seventy-five years (75 years).
- If diagnosed with a covered critical illness within six (6) months of the effective date of the approval, that critical illness will not be eligible for benefit for the life of the Rider, unless that critical illness was a direct result of an Accident within six (6) months immediately following the effective date of the Applicant's application.
- All premiums paid will be refunded without interest under the Critical Illness Rider if the Applicant dies while the Policy is still in effect.

Your Critical Illness Benefits:

The Rider will allow a specific benefit payment based on coverage option chosen by the Applicant upon the diagnosis of a specified critical illness condition for the Applicant covered under this Rider prior to age 75.

The following critical illnesses defined in the Rider are covered:

- Cancer
- Stroke
- Major Burns
- Heart Attack
- Paralysis

What are the Critical Illness Rider exclusions?

Benefits under the Critical Illness rider are not payable if the specified critical illness condition is caused either directly or indirectly from the following:

- Willful self-inflicted injury or illness.
- Willful misuse or abuse of drugs and/or alcohol.
- Committing or attempting to commit a crime or any involvement in criminal activity.
- Poison, inhaled poisonous gases or vapors.
- Pre-existing condition(s) for which you received medical advice, consultation, or treatment on or prior to the effective date of coverage under the Rider.
- Bodily injury through external and violent means which was not the result of an Accident.
- Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex or infection by HIV virus.
- If the Applicant is injured or becomes ill directly or indirectly from warlike action by a military force, insurrection, revolution, terrorism, usurped power, or action taken by governmental authority in hindering or defending against any of these.
- If the Applicant is injured or becomes ill directly or indirectly from Nuclear reaction, radiation, or radioactive contamination.