

SECTION 1: PRIMARY INSURED INFORMATION

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

ADDITIONAL DUE DILIGENCE AND TAX RESIDENCY INFORMATION

- 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
- 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:
 - Full Name of PEP:
 - Job Title/Position of PEP:
 - Nature of relationship to PEP (if not yourself):
- Do you hold citizenship/ nationality/ residency status or are required to file taxes in another country/ countries: Yes No
- 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

Primary Insured
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.

PRIMARY INSURED'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 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 Primary Insured: _____

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 THE PRIMARY INSURED'S IDENTIFICATION (NATIONAL ID, DRIVERS PERMIT, PASSPORT) TRN AND PROOF OF ADDRESS (E.G. UTILITY BILL OR BANK STATEMENT NOT OLDER THAN 3 MONTHS) MUST BE SUBMITTED WITH THIS DELETION REQUEST. IF REQUIRED DOCUMENTS ARE NOT SUBMITTED, THE DELETION REQUEST WILL BE PLACED ON HOLD.

SECTION 2: PLEASE COMPLETE THE INFORMATION BELOW.

ENTER NAMES OF PERSONS TO BE DELETED.		DATE(S) OF BIRTH AND ID NUMBER(S)	
1	<input type="text"/>	D.O.B	<input type="text"/> dd/mm/yyyy
PARENT, PARENT IN LAW OR STEP-PARENT	GENDER M <input type="checkbox"/> F <input type="checkbox"/>	ID #	<input type="text"/>
2	<input type="text"/>	D.O.B	<input type="text"/> dd/mm/yyyy
PARENT, PARENT IN LAW OR STEP-PARENT	GENDER M <input type="checkbox"/> F <input type="checkbox"/>	ID #	<input type="text"/>
3	<input type="text"/>	D.O.B	<input type="text"/> dd/mm/yyyy
SPOUSE/SIGNIFICANT OTHER	GENDER M <input type="checkbox"/> F <input type="checkbox"/>	ID #	<input type="text"/>
4	<input type="text"/>	D.O.B	<input type="text"/> dd/mm/yyyy
CHILD	GENDER M <input type="checkbox"/> F <input type="checkbox"/>	ID #	<input type="text"/>
5	<input type="text"/>	D.O.B	<input type="text"/> dd/mm/yyyy
CHILD	GENDER M <input type="checkbox"/> F <input type="checkbox"/>	ID #	<input type="text"/>

SECTION 3: DECLARATION & DATA PROTECTION

DECLARATION:

I understand that coverage for the person(s) I have opted to delete from the plan will cease on the day that the form is signed and dated.

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 Primary Insured: _____

Date: _____

dd/mm/yyyy