THE FAMILY INDEMNITY PLAN

CHANGE OF PLAN FORM

RESET

CUNA CARIBBEAN INSURANCE

The Effective Date of Coverage for this Change of Plan will always be the first day of the month following the date paid indicated on this form.

SECTION 1: Please fill out your information below:

MEMBER'S FIRST NAME	MIDDLE NAME	LAST NAME

DATE OF BIRTH: _____ **GENDER:** _____ **IDENTIFICATION:** ID _____

MOBILE No.: _____ **TELEPHONE:** _____

EMAIL: _____ **OTHER:** _____

ADDRESS: _____

_____

CITY: _____ **COUNTRY OF BIRTH:** _____

COUNTRY OF RESIDENCE: _____

ORGANISATION/ FIP PROVIDER: _____

MEMBERSHIP No.: _____

SECTION 2: Please fill out the information below if you are applying for a **Change of Plan** for your Family Indemnity Plan certificate:

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Choose your new Coverage Option. Click on the dropdown tab:

1. **In table 'A' to select your current plan type.**
2. **In table 'B' to select your new plan type.**

A	Current Plan Type	Select Plan
	Individual Benefit	$ 0.00
	Monthly Premium	$ 0.00

B	New Plan Type	Select Plan
	Individual Benefit	$ 0.00
	Monthly Premium	$ 0.00

If you are the only insured for FIP or the other insureds are all minors, you must complete a Designation of Beneficiary Form.

SECTION 3: Please fill out the information below if you are applying for a **Change of Plan** for your Critical Illness Rider:

THE CRITICAL ILLNESS RIDER

PLEASE CHECK BOX IF YOU WISH TO MODIFY YOUR CI RIDER COVERAGE ☐

Select the new Coverage Option of your choice by clicking on dropdown tab:

Age Band	
Coverage Option	$ 0.00
Monthly Premium	$ 0.00

1. Have you ever been diagnosed with any of the following: Cancer, Heart Attack, Stroke, Paralysis OR Major Burns? _____

   1b. If yes, please indicate the details_____

2. 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, stroke, heart attack, major burns, paralysis and cancer? _____

   2b. If yes, please indicate the details_____

The premium for your Change of Plan will be applied from the first day of the following month.

FOR OFFICIAL USE ONLY. To be completed by the Organisation or FIP Provider

FIP Premium:	$ 0.00
CI Rider Premium:	$ 0.00
Total Premium Due:	$ 0.00

Date Paid _____ (DD / MM / YYYY)

Payment cheque/receipt No.: _____

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TERMS AND CONDITIONS

The Family Indemnity Plan: It is the sole responsibility of the Member to ensure that eligible persons for whom application is being made are not persons who have existing coverage under The Family Indemnity Plan at any other Institution. No person(s) may be insured through more than one Family Indemnity Plan Certificate in accordance with the Non-Duplication of Coverage clause contained in the Policy and the Member's Family Indemnity Plan Certificate. If a person is named under more than one Family Indemnity Plan Certificate, on the death of such a person, the Insurer shall only be liable to pay one claim.

Premium Rates
Premium rates are based upon the experience of the Plan and shall be reviewed annually and may be changes no more than once a year. If the premium rate is changes, you will be given 31 days advanced written notice.

Critical Illness Rider (if applicable): Benefits payable shall be in accordance with covered conditions (Cancer, Heart Attack, Stroke, Paralysis and Major Burns), as specified in the respective Rider, which shall be subject to the following provisions;: 1) The CI Rider, is only available to the Primary Insured Member, all other Insured listed on the Member Certificate shall have basic coverage under the FIP Plan; 2) The maximum age of entry for enrollment into the Rider is fifty nine (59) years;. 3) Coverage under this rider will automatically terminate at age seventy-five (75); 4) The Rider will allow a specific benefit payment based on coverage option chosen by the Primary Insured upon the diagnosis of a specified critical illness condition; 5) If diagnosed with a covered critical illness, within six (6) months of the effective date of the Primary Insured Member's enrollment, 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 six (6) months immediately following the effective date of the Primary Insured Member's enrollment; 6) Benefits under this Rider are not payable if the covered condition is caused either directly or indirectly from the following pre-existing condition(s) for which he/she received medical advice, consultation or treatment on or prior to the effective date of enrollment on this rider; 7) We shall refund premium, without interest, if the Primary Insured Member dies and the CI Rider is still in effect; 8) Upon termination of this Rider, only the proportion of Critical Illness premiums which has not yet been earned will be refunded; 9) The Primary Insured Member may change to a higher coverage option only after the initial six-month waiting period has elapsed and no more than once every 12 months.
NB: The monthly premium payable for the Primary Insured is based on the attained age and the selected coverage limit, maximum age for change of CI Coverage is 59 years. The premium amount payable for each coverage amount applied for remains the same for that coverage amount throughout the lifetime of the certificate for the Primary Insured, subject to any changes arising from annual premium rate reviews.

Definitions of Specified Critical Illness

Cancer: Being a malignant tumor characterized by the uncontrolled growth and spread of malignant cells. Incontrovertible evidence of the invasion of tissue or definite history of malignant growth must be produced. The term "cancer" also include Leukemia (other than Chronic Lympocytic Leukemia) and Lymphomas or Hodgkins' disease, but excludes Kaposi's sarcoma, non-invasive cancers in situ, any skin cancer other than malignant melanomas, localized non-invasive tumors showing only early malignant changes and tumors in the presence of a Human Immunodeficiency Virus (HIV).

Heart Attack: Being the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area; the diagnosis evident by all of (i) a history of typical chest pain, (ii) new electrocardiograph changes, (iii) elevated levels of cardiac enzymes.

Stroke: Being a cerebrovascular incident, producing neurological sequelae lasting more than twenty-four (24) hours. Evidence of permanent neurological deficit must be produced. This includes: a) Infarction of brain tissue; b) Intra-cranial and/or subarachnoid hemorrhage, and; 3) Embolism from an extra cranial source. The diagnosis must be unequivocal and supported by hospitalization records which indicate a cerebrovascular incident within a period

Paralysis: Being the total and permanent loss or use of two or more limbs through paralysis due to loss of nerve function.

Major Burns: Third degree burns covering at least twenty (20) percent of the surface area of the Primary Insured Member's body.

APPLICANT DECLARATION:

I understand that the Effective Date of Coverage, on the approved Change of Plan endorsement letter, will always be the first day of the month following the date paid indicated on this form.

I also understand that where I am applying for a **Change of Plan** under **The Family Indemnity Plan (FIP)** and that starting from the effective date of coverage, I will be subject to a six-month waiting period during which time only claims arising from accidental death will be paid at the benefit amount listed on the higher plan, and; claims resulting from death by natural causes will be paid at the benefit amount listed on the lower plan.

I also understand that where I am applying for a **Change of Plan** under **The FIP Critical Illness Rider** that starting from the effective date of coverage, I will be subject to a six-month waiting period, during which time only critical illness claims arising as a direct result of an accident and immediately following the effective date of my enrolment, will be paid at the benefit amount listed on the higher plan, and; where critical illness claims arise due to natural causes and immediately following the effective date of my enrolment, the benefit will be paid at amount listed on the lower plan.

I certify that, to the best of my knowledge and belief, all statements contained in this Change of Plan form 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.

I agree to receive direct communication from CUNA Caribbean Insurance Society Limited (CCISL) via written notice, SMS, email, etc. about information pertaining to my insurance coverage and other products and services offered by the company.

By signing this document I confirm that I have read and understand the above information.

Signature of Member	**Signature of Authorized Organisation Officer**
Date: 30/04/2020	**Date:**
DD / MM / YYYY	**DD / MM / YYYY**