THE FAMILY INDEMNITY PLAN
CHANGE OF INSURED FORM

CUNA CARIBBEAN INSURANCE

SECTION 1: MEMBER INFORMATION

FIRST NAME | MIDDLE NAME | LAST NAME

DATE OF BIRTH (DD / MM / YYYY) | GENDER M ☐ F ☐ | ID ☐ DP ☐ PP ☐ BC ☐ (ENTER ID NUMBER)

MOBILE NO. | OTHER TELEPHONE NO. | EMAIL ADDRESS

MAILING ADDRESS

CITY | COUNTRY OF BIRTH | COUNTRY OF RESIDENCE

CERTIFICATE NO

NB: A COPY OF PICTURE IDENTIFICATION (PASSPORT, NATIONAL ID, DRIVERS PERMIT), BIRTH CERTIFCATE AND PROOF OF ADDRESS (UTILITY BILL OR BANK STATEMENT NOT OLDER THAN 3 MONTHS) MUST BE SUBMITTED WITH THIS APPLICATION. IF REQUIRED DOCUMENTS ARE NOT SUBMITTED APPLICATION WILL BE PLACED ON HOLD AND NO CHANGE TO COVERAGE WILL BE EFFECTED.

SECTION 2: Please select the event that applies and complete the information below. Complete another form if more than four changes are required

☐ Divorce of the Member ☐ Child marries ☐ Child has reached age 26 ☐ Re-marriage of Member

Enter names of persons to be added or deleted and select the checkbox next to "Add" or "Delete" to indicate the action to be performed. Circle the relationship the person bears to you	DATE(S) OF BIRTH and ID NUMBER(S)	SIGNATURE OF PROPOSED INSURED PERSON (persons over 18)
1 [redacted] PARENT or PARENT IN LAW Sex: ☐ M ☐ F ☐ ADD ☐ DELETE	DD / MM / YY ID/DP/PP/Birth certificate No.:	I agree to be listed as an Insured Person under Policy number stated above
[redacted] PARENT or PARENT IN LAW Sex: ☐ M ☐ F ☐ ADD ☐ DELETE	DD / MM / YY ID/DP/PP/ Birth certificate No.:	I agree to be listed as an Insured Person under Policy number stated above
[redacted] SPOUSE/COHABITANT Sex: ☐ M ☐ F ☐ ADD ☐ DELETE	DD / MM / YY ID/DP/PP Birth certificate No.	I agree to be listed as an Insured Person under Policy number stated above
[redacted] SPOUSE/COHABITANT Sex: ☐ M ☐ F ☐ ADD ☐ DELETE	DD / MM / YY ID/DP/PP Birth certificate No.:	I agree to be listed as an Insured Person under Policy number stated above
[redacted] CHILD Sex: ☐ M ☐ F ☐ ADD ☐ DELETE	DD / MM / YY ID/DP/PP Birth certificate No.:	I agree to be listed as an Insured Person under Policy number stated above (Sign if over the age of 18)

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DECLARATION:

I understand that coverage for the person(s) I have opted to delete from the certificate will cease immediately upon submission of this form. The person(s) being added, subject to approval by CUNA Caribbean Insurance (CCI), will be the newly insured under the Certificate and subject to the Terms and Conditions contained therein and may be subject to a waiting period to become eligible for benefits.

I understand that no person may be covered under more than one certificate issued by CCI, and I have verified that all person(s) being added on this form, to the best of my and their knowledge, are not covered under any other certificate and are eligible to be insured under my certificate. Where a proposed insured person is insured on more than one certificate underwritten by CCI and the duplication was caused due to a misstatement made by the proposed Insured Person, the benefit payable on the life of that person will be reduced by fifty percent if more than three (3) years have elapsed from the date when this application was signed. If less than three (3) years have elapsed since the date this application was signed or where the applicant knowingly misstated the information, or the misstated information is material to the risk assumed by CCI no benefit will be payable.

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.

I agree to receive direct communication from CCI via written notice, SMS, email, etc. about information pertaining to my insurance coverage.

I agree to receive direct communication from CCI via written notice, SMS, email, etc. in relation to other products and services which may be offered by the company. Yes ☐ No ☐

Applicant's Consent to Processing of Personal Information:

I consent to CCI and where applicable, the Policyowner or Administrator, accessing and further processing my personal data, the personal data of my dependents and other information required for and pertaining to my insurance coverage, evaluation, payment of benefits and matters related thereto.

Yes ☐ No ☐

NB: If you do not consent to the processing of the personal information supplied on this form, please do not submit this application and destroy this application to ensure protection of the personal information contained herein.

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

Signature of Member: _____ **Date:** DD / MM / YY

DATA PROTECTION COMMITTMENT:

We are 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.