THE FAMILY INDEMNITY PLAN ENROLMENT FORM

CUNA CARIBBEAN INSURANCE

SECTION 1: MEMBER INFORMATION

FIRST NAME	MIDDLE NAME	LAST NAME
DATE OF BIRTH	**GENDER**	**ID ☐ DP ☐ PP ☐ BC ☐**
DD / MM / YYYY	M ☐ F ☐	ENTER ID NUMBER
MOBILE NO.	**OTHER TELEPHONE NO.**	**EMAIL ADDRESS**

MAILING ADDRESS

CITY	COUNTRY OF BIRTH	COUNTRY OF RESIDENCE

ADDITIONAL DUE DILIGENCE AND FATCA INFORMATION

1. Are you, or any of your immediate family members or close associates, currently or have been within the last five years, a PEP* or have close association with such individuals, either domestically or internationally? Yes ☐ No ☐
2. Are you a U.S. citizen or resident? Yes ☐ No ☐
3. Do you have a U.S. address (residence, correspondence or P.O. Box)? 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 ☐

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.

NB: If you responded "Yes" to any of the questions above we shall contact you within 5 business days of receipt of this application to obtain additional information necessary to complete your enrolment.

NB: A COPY OF PICTURE IDENTIFICATION (NATIONAL ID, DRIVERS PERMIT, PASSPORT) or 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 COVERAGE WILL BE EFFECTED. WE MAY REQUEST ADDITIONAL DOCUMENTATION AS IS NECESSARY PRIOR TO ISSUING A CERTIFICATE,

You must complete a DESIGNATION OF BENEFICIARY Form if you are the only person on this enrolment form or if all other additional persons are minors.

SECTION 2: Select the PLAN of your choice from the Coverage options. Premium and Coverage amount is listed next to the corresponding Plan:

PLAN (Death Benefit)	A	B	C	D	E	F	G
Coverage Amount	$10,000.00	$15,000.00	$20,000.00	$30,000.00	$40,000.00	$65,000.00	$100,000.00
Monthly Premium	$63.40	$95.10	$126.80	$190.20	$253.60	$412.10	$634.00

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: $ 50,000.00	$35.00 ☐	$71.50 ☐	$149.00 ☐	$224.50 ☐
	Option 2: $ 100,000.00	$70.00 ☐	$143.00 ☐	$298.00 ☐	$449.00 ☐
	Option 3: $ 150,000.00	$105.00 ☐	$214.50 ☐	$447.00 ☐	$673.50 ☐
	Option 4: $ 300,000.00	$210.00 ☐	$429.00 ☐	$894.00 ☐	$1,347.00 ☐
	Option 5: $ 450,000.00	$315.00 ☐	$643.50 ☐	$1,341.00 ☐	$2,020.50 ☐
	Option 6: $ 600,000.00	$420.00 ☐	$858.00 ☐	$1,788.00 ☐	$2,694.00 ☐

1. Have you ever been diagnosed with any of the following: cancer, heart disease of any kind, stroke, paralysis, burns, diseases of the nervous system, deafness, speech issues or mental disorders?

   Yes No

   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, heart disease of any kind, stroke, paralysis, burns, diseases of the nervous system, deafness, speech issues, organ failure or mental disorders of any kind?

   Yes No

   2b. If yes, please indicate the details

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

Only persons bearing the following relationships to the Member qualify for Coverage. Coverage is not automatic and is subject to approval by CUNA Caribbean Insurance (CCI). Persons approved for coverage will be listed on the certificate issued by CCI to the Member.

1. Spouse or Cohabitant under the age of 76. Where naming a cohabitant an affidavit as proof of relationship must be supplied. Only one spouse or cohabitant may be covered for the life of the certificate.
2. Children under the age of 26 which includes biological children, stepchildren, children under your guardianship or children in whose lives You have Insurable Interest and that such insurable interest can be satisfied by proof. A maximum of five (5) children can be covered by the plan
3. Parents under the age of 76 which includes biological or stepparents of your spouse or yourself on whom you are dependent for support or in whose life you bear a pecuniary interest. Proof of dependency or pecuniary interest is to be supplied at the time of enrolment. Only two parents may qualify for coverage.

This section is to be completed in entirety. Enter names of additional persons and circle the relationship which they bear to you. Enter the date of birth in DD/MM/YYYY format	IDENTIFICATION ID = National ID PP = Passport DP = Drivers Permit BC = Birth Certificate	SIGNATURE OF ADDITIONAL PERSONS (persons 18 years or older)
1 PARENT or PARENT IN LAW Date of Birth: DD/MM/YYYY Sex: M ☐ F ☐	ID ☐ DP ☐ PP ☐ BC ☐	I confirm that I have read, understood, and agree to the DECLARATION section below.
2 PARENT or PARENT IN LAW Date of Birth: DD/MM/YYYY Sex: M ☐ F ☐	ID ☐ DP ☐ PP ☐ BC ☐	I confirm that I have read, understood, and agree to the DECLARATION section below.
3 SPOUSE or COHABITANT Date of Birth: DD/MM/YYYY Sex: M ☐ F ☐	ID ☐ DP ☐ PP ☐ BC ☐	I confirm that I have read, understood, and agree to the DECLARATION section below.
4 CHILD Date of Birth: DD/MM/YYYY Sex: M ☐ F ☐	ID ☐ DP ☐ PP ☐ BC ☐	I confirm that I have read, understood, and agree to the DECLARATION section below. (Sign if 18 years or older)
5 CHILD Date of Birth: DD/MM/YYYY Sex: M ☐ F ☐	ID ☐ DP ☐ PP ☐ BC ☐	I confirm that I have read, understood, and agree to the DECLARATION section below. (Sign if 18 years or older)
6 CHILD Date of Birth: DD/MM/YYYY Sex: M ☐ F ☐	ID ☐ DP ☐ PP ☐ BC ☐	I confirm that I have read, understood, and agree to the DECLARATION section below. (Sign if 18 years or older)
7 CHILD Date of Birth: DD/MM/YYYY Sex: M ☐ F ☐	ID ☐ DP ☐ PP ☐ BC ☐	I confirm that I have read, understood, and agree to the DECLARATION section below. (Sign if 18 years or older)
8 CHILD Date of Birth: DD/MM/YYYY Sex: M ☐ F ☐	ID ☐ DP ☐ PP ☐ BC ☐	I confirm that I have read, understood, and agree to the DECLARATION section below. (Sign if 18 years or older)

DECLARATION:

I understand that no person may be covered under more than one certificate issued by CUNA Caribbean Insurance (CCI), 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 certificate. Where either the Member or an additional person is insured on more than one certificate underwritten by CCI and the duplication was caused due a misstatement made by the Member or an additional person, as appropriate, the Benefit payable on the life of that person or Member, will be reduced by fifty percent if more than three (3) years have elapsed from the date when this enrolment was signed. If less than three (3) years have elapsed since the date this enrolment was signed or where the Member of person knowingly misstated the information, or the misstated information is material to the risk assumed by CCI no benefit will be payable.

I understand that I am applying for coverage under the Family Indemnity Plan and that coverage for persons listed on this enrolment is not automatic and is subject to acceptance and approval of my enrolment by CCI. Approval, if granted, will be communicated to me and a certificate bearing the full terms and conditions will be issued by CCI. **Waiting period(s)** will be stated on the certificate, 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 certificate. 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 certificate.

I understand that if insurance is approved for additional persons listed herein that Benefits will be paid to me as the Member. I agree that should I, the Member, predecease the other insureds listed in the certificate 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 cohabitant; if no spouse or cohabitant is listed, to the unmarried, insured children or their legal guardian if they are not over 18 equally; if no children are listed, to insured Parents equally.

I agree to be bound by the terms and conditions of the Family Indemnity Plan and continued payment of premiums to CCI 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.

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I agree to receive direct communication from CCI via written notice and electronic means including SMS, WhatsApp and email, about information pertaining to my insurance coverage. Yes ☐ No ☐

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

Member's Consent to Processing of Personal Information:

I, the Member and additional person(s) 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. I further agree to my personal data being shared with governmental or regulatory authorities where required by applicable law.
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, and other applicable laws 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.

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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 eight (8) eligible family Members
- No medical examination is required for coverage.
- Coverage ceases for Children insured 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.
- Terminal Illness coverage for the Member or Insured Persons at no additional cost. Conditions apply.
- Accidental Death coverage for the Member only. Double the lumpsum payment if the Member dies as a result of an Accident prior to attaining age 60 and after completion of Waiting period as stated in the certificate.
- Optional Critical Illness coverage is available for the Member 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 certificate 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.

Additionally, Benefits for Terminal Illness are not payable if the Terminal Illness occurs as a result of sickness or injury for which the Member or Insured Person received medical advice, consultation or treatment prior to the effective date of the certificate and the Terminal Illness occurs within twenty-four (24) months of the effective date of the certificate.

How does the Critical Illness Rider Work?

- The CI Rider is available in addition to any plan indicated on the form. There are six (6) 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 Member, 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 Member 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 Member's enrolment.
- All premiums paid will be refunded without interest under the Critical Illness Rider if the Member dies while the certificate is still in effect.

Your Critical Illness Benefits:

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

The following critical illnesses defined in the Rider are covered:

- Cancer
- Heart Attack
- Stroke
- Paralysis
- Major Burns
- Coronary Artery Bypass
- Alzheimer's Disease
- Deafness
- Loss of Speech
- Multiple Sclerosis

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 Member 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 Member is injured or becomes ill directly or indirectly from Nuclear reaction, radiation, or radioactive contamination.