The Family Critical Illness Plan
ADDITIONAL INSUREDS' ENROLMENT FORM

CUNA CARIBBEAN INSURANCE

Please write in BLOCK letters, mark all choice boxes with and 'X'
Applicant must complete all sections.

	YES	NO
1. Have you previously had a Family Critical Illness Plan certificate?	[ ]	[ ]
2. Are you or any person(s) who will be enrolled on this certificate, enrolled on another Family Critical Illness Plan?	[ ]	[ ]

First Name **Middle Name** **Last Name**

Date of Birth: (D D M M Y Y Y Y) **Primary Insured Membership's No.:** **Sex:** Male [ ] Female [ ]

Proof of Age Submitted:
Birth Certificate [ ] Driver's License [ ] Passport [ ] ID Card [ ] Utility Bill [ ]

Proof of Address Submitted:
Registered Mail [ ]

Organization: _____

Residential Address: _____
Street *City* *Country* *Zip Code*

Mailing Address (*If different from above):* _____
Street *City* *Country* *Zip Code*

Telephone: (Home) (Work) (Mobile)

Email address:

Name of Primary Insured / Relationship to Primary Insured:

Proof of Relationship Submitted: _____

Please answer the following questions.

1.Have you ever been treated or diagnosed with:	**Y-YES**	**N-NO**
Cancer [ ] Heart Attack [ ] Stroke	[ ]	
Paralysis, [ ] Major Burns [ ] Coma	[ ]	
HIV [ ] Heart Conditions [ ] Diabetes [ ]		

2a. Have you received, in the last five (5) years, any medical attention or advice or surgical treatment or been hospitalized? [ ]

2b. If yes, please indicate the details _____

_____

Benefits under this Policy are not payable if the diagnosis of a Critical Illness covered results either directly or indirectly from AIDS or HIV virus during the five years of continuous coverage immediately following the effective date of enrolment

We will not pay a benefit if an Insured Person is diagnosed with a Critical Illness caused either directly or indirectly from any disease, health condition or bodily injury for which the Insured Person received medical advice, consultation, diagnosis or treatment prior to the Effective Date of the Plan for the Insured Person and which disease, health condition or bodily injury was known to the Insured Person and/or the Primary Insured and was not fully and truthfully disclosed to us prior to the Effective Date of coverage.

BENEFIT INFORMATION

1. The monthly premium payable for the Primary Insured is based on the issue age and the selected coverage limit.
2. The maximum enrollment age for adults is 59 years up to and including day before the 60th birthday and 25 years in the case of the Primary Insured's children.
3. Termination age is 26 years for the Primary Insured's unmarried children who are not permanently disabled and 75 years for all other Insured Persons.
4. The premium amount payable for each coverage amount applied for remains the same for that coverage amount throughout the lifetime of the certificate for each Insured Person.
5. The Primary Insured will be required to collect the benefit for all Insured Persons once alive and medically able to do so.

Please indicate the MONTHLY PREMIUM that corresponds with your AGE and COVERAGE LIMIT:

Coverage Option – Additional Insured Person
Monthly Premium Per Person

Age Band (Yrs)	$50,000		$100,000		$150,000		$200,000	
<35	☐	$32.85	☐	$65.70	☐	$98.55	☐	$131.40
35-44	☐	$67.50	☐	$135.00	☐	$202.50	☐	$270.00
45-54	☐	$141.30	☐	$282.60	☐	$423.90	☐	$565.20
55-59	☐	$212.85	☐	$425.70	☐	$638.55	☐	$851.40

Please indicate the coverage limit of the Primary Insured: _____

Please note that the coverage amount of the additional Insured Persons cannot be more than that of Primary Insured.

Amount Due: . Date Paid: (D D M M Y Y Y Y)

PRIMARY INSURED'S SIGNATURE_____ **MM / DD / YY** _____/_____/_____

(To be completed by all additional enrolees over the age of 18 years)

I acknowledge that this Plan has been issued based on the information provided in The Family Critical Illness Plan Enrolment Form for insurance. I confirm that I have read carefully and given _____ (Primary Insured) authorization to apply for coverage on my behalf. I understand that:

- If, I am no longer interested in the insurance and elect to cancel this policy, I must submit a written request to terminate my coverage.
- I am being enrolled for the Family Critical Illness Plan coverage and therefore will be subject to a six months waiting period during which **no claim** is payable on diagnosis of a covered critical illness other than one directly resulting from an accident.
- The Order of Payment and Designation of Authorization as outlined in Policy dictates the payment of benefit and refund.

I hereby authorize and consent to the Primary Insured submitting medical reports in relation to me to CUNA Caribbean Insurance Society Ltd upon a claim being made and collecting the benefit of said claim on my behalf.

I hereby authorize CUNA Caribbean Insurance Society Limited or its representative to obtain information and records from any physician or medical professional having information with respect to my physical or mental condition for the purpose of the Family Critical Illness Plan (including for processing any claim) and also specifically consent to such physician or medical professional disclosing such information to CUNA Caribbean Insurance Society Limited or its representative.

I understand and certify that, to the best of my knowledge and belief, all statements contained in this enrolment 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 maybe be null and void or maybe adjusted based on true state of affairs.
I hereby agree to receive notices and other information from CUNA Caribbean Insurance Society Limited.
I have read and understood the above information. In confirmation of this, I have signed and dated this document.

Enrolment Taken By: _____ **PRINT NAME OF STAFF** _____ **DATE** _____/_____/_____

PRIMARY INSURED'S SIGNATURE_____ **Date [MM / DD / YY]** _____/_____/_____

ADDITIONAL INSURED'S SIGNATURE_____ (18 years and older) **Date [MM / DD / YY]** _____/_____/_____

**Premium rates are subject to change. All Benefits and Provisions are subject to the Terms and Conditions of the Policy which is available at your Institution. Insurance coverage is subject to approval by CUNA Caribbean Insurance Society Limited (CCISL). Insurance coverage is not enforced until a certificate has been issued by CCISL.