THE FAMILY INDEMNITY PLAN

CHANGE OF PLAN/COVERAGE FORM

CUNA CARIBBEAN INSURANCE JAMAICA LTD.

Select the option(s) that apply: ☐ THE FAMILY INDEMNITY PLAN ☐ CRITICAL ILLNESS RIDER

Section 1: Please complete the information below:

POLICYHOLDER/PRIMARY INSURED FIRST NAME | **MIDDLE NAME** | **LAST NAME**

DATE OF BIRTH: DD / MM / YYYY **GENDER:** M ◯ F ◯ **ID TYPE & NO.:**

MOBILE NO.: **OTHER CONTACT NO.:**

EMAIL:

ADDRESS:

CITY: **COUNTRY OF BIRTH:**

COUNTRY OF RESIDENCE:

ADMINISTRATOR: **BRANCH:**

ACCOUNT NO.:

SECTION 2: Please complete the section below if you are applying for a CHANGE OF PLAN for your FAMILY INDEMNITY PLAN POLICY:

THE FAMILY INDEMNITY PLAN

Current Plan: A ◯ B ◯ C ◯ D ◯ E ◯ F ◯ G ◯

Select the Plan Change option of your choice:

Plans	A	B	C	D	E	F	G
Individual Benefit	$80,000	$120,000	$150,000	$250,000	$400,000	$650,000	$1,000,000
Monthly Premium	$422.40	$633.60	$792.00	$1,320.00	$2,112.00	$3,432.00	$5,280.00

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

SECTION 3: Please complete the section below if you are applying for CHANGE OF COVERAGE for your CRITICAL LILLNESS RIDER

THE 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	Coverage: $500,000	$350.00 ☐	$715.00 ☐	$1,490.00 ☐	$2,245.00 ☐
	Coverage: $1,000,000	$700.00 ☐	$1,430.00 ☐	$2,980.00 ☐	$4,490.00 ☐

1. Have you ever been diagnosed with any of the following: Cancer, Heart Attack, Stroke, Paralysis OR Major Burns? 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, stroke, heart attack, major burns OR paralysis? Yes ☐ No ☐

   2b. If yes, please indicate the details_____

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

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TERMS AND CONDITIONS OF SERVICE

All Benefits and Provisions are subject to the Terms and Conditions of the Family Indemnity Plan (FIP) Policy and/or Critical Illness Rider that was issued to you.

APPLICANT'S (POLICYHOLDER) 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 signed date 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, in the event of a change to a higher Plan, **a six (6) month waiting period** applies. If death occurs during the six-month waiting period, Benefits will be paid based on the lower Plan. However, where the death of an Insured Person occurs as a result of an accident during the six (6) month waiting period, the Benefit will be paid based on the higher Plan.

In the event of a change to a lower Plan, Benefits based on the lower Plan become effective on the first of the month following the date on which the application was made for the change.

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 (6) 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 application, will be paid at the higher coverage amount, and; where critical illness claims arise due to natural causes and immediately following the effective date of my application, the benefit will be paid at the lower coverage amount. In the event of a change to lower coverage, Benefits based on the lower coverage become effective on the first of the month following the date on which the application was made for the change.

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 consent to CUNA Caribbean Insurance Jamaica Limited (CCIJ) and the Administrator having access to information required for and pertaining to my insurance coverage and matters related thereto. Further, I hereby authorize CUNA Caribbean Insurance Jamaica Limited (CCIJ) to process information and/or data provided by me, relevant to my insurance coverage and the payment of benefits.

I agree to receive direct communication from CUNA Caribbean Insurance Jamaica Limited (CCIJ) 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 understood the above information.

_____	_____
Name of Policyholder/Primary Insured	**Name of Administrator's Representative**
_____	_____
Signature of Policyholder/Primary Insured	**Signature of Administrator's Representative**
Date: _____	**Date:** _____
DD / MM / YYYY	**DD / MM / YYYY**