

Date: _____

The Insurance Department
TECU Credit Union

CUNA – Family Indemnity Plan

I hereby authorize **TECU CREDIT UNION** to deduct my F.I.P. premium monthly from my account as follows:

Share Account

Plan A Plan B Plan C Plan D Plan E Plan F Plan G

Critical Illness Rider

FCIP

Effective Date of Insurance: _____

Member Number: _____

Member Name: _____

Member Signature: _____

FIP01200911

For Official Use Only

Grid for official use only

The Family Indemnity Plan MEMBER ENROLLMENT FORM

Please write in BLOCK letters and WITHIN THE BOXES, AVOIDING CONTACT WITH THE EDGE OF THE BOX 1 2 3 4; mark all choice boxes with an X and NOT with a tick (✓)

- 1. Have you previously had a Family Indemnity Plan certificate?
2. Are you or any person(s) who will be listed below presently covered under another Family Indemnity Plan certificate?
3. Open Enrollment Period Applicable? Yes No From To

Organisation

Grid for Organisation name

Membership No. Grid

Member Telephone No. Grid

MAILING ADDRESS OF MEMBER

Street, City, Country address grids

Please complete a Designation of Beneficiary Form if you are the only person on this form or if all insureds are minors.

Table with 4 columns: Name, Date of Birth (MM, DD, YYYY), Sex (M/F), Relationship to Member/Self. Includes 'Primary Insured Member' label.

Plan Selected and Benefit Amount grids

Please include the premium payment along with this Enrollment Form.

Amt. Paid and Date Paid (MM, DD, YYYY) grids

Please turn this form over to read and sign your agreement to the Terms and Conditions of Service of the Family Indemnity Plan.



TERMS AND CONDITIONS OF SERVICE

1. We reserve the right to request proof of all the information. The effective date of your certificate will always be the first of the month following the date of the enrollment.
2. If enrolling for Family Indemnity coverage outside of the "Open Enrollment Period" you the member, along with the other Insured Persons will be subject to a six-months Waiting Period before full coverage begins. During the six-month waiting period benefits will only be paid for accidental death.
3. **It is the sole responsibility of the Member to ensure that eligible persons for whom applications are being made, are not primary insured persons who have existing coverage under the Family Indemnity Plan as no person may be insured through more than one Family Indemnity Plan Certificate in accordance with the Non-Duplication of Coverage clause contained in the Primary Insured 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 the claim made under the Family Indemnity Plan certificate that is first in time.**
4. Premium rates are based upon the experience of the plan and shall be reviewed annually and may be changed no more than once a year. If we change the premium rate, we will give you thirty-one (31) days advance written notice.
5. I understand and certify that, to the best of my knowledge and belief, all statement contained in this enrollment 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.
6. **I acknowledge that I have read and understood the Terms & Conditions of Service as stated above.**
7. **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.**

Signature of Member

Date Signed

--	--

 -

--	--

 -

--	--	--	--

MM DD YYYY

Signature of Authorised Organisation Officer

Date Signed

--	--

 -

--	--

 -

--	--	--	--

MM DD YYYY