CUNA CARIBBEAN INSURANCE
JAMAICA LTD.

THE FAMILY INDEMNITY PLAN

CHANGE OF INSURED FORM

Insured's Name _____

Certificate No. _____ Membership/Account No. _____

Organization _____

This Change of Insured shall be effective on the first day of the month following the date the member signs this form and delivers it to the Organization through which he/she holds his/her certificate and the Organization files the Change of Insured form with the office administering the plan.

Upon the occurrence of any of the following events to an Insured Person, the Member may name a replacement Insured Person. If you do not inform the Organization of the event within 30 days, there will be a **six (6) month waiting period** for benefits due to natural death (accidental death benefits will be paid).

Check the event that applies:

☐Divorce of the Member ☐Child marries ☐Child has reached age 26

☐Re-marriage of Member ☐Death of an Insured

PERSON BEING DELETED

LAST NAME	FIRST NAME	DATE OF BIRTH DD / MM / YY			AGE	SEX	RELATIONSHIP TO MEMBER

OR

PERSON BEING ADDED

LAST NAME	FIRST NAME	DATE OF BIRTH DD / MM / YY			AGE	SEX	RELATIONSHIP TO MEMBER

I understand that there will no longer be any coverage for the person being deleted from the plan. The person being added (who is not a replacement insured person) will be a new insured under the plan and will be subject to a six (6) month waiting period for benefits due to natural death. _____(signature of member)

At no time may more than six (6) persons be insured under one certificate.

It is the sole responsibility of the Member to ensure that eligible persons for whom application is being made are not persons who have existing coverage under The Family Indemnity Plan at any Organization/Institution. 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 Family Indemnity Plan Policy. 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 one claim.

Signature of Member _____ Date_____/_____/_____
DD / MM / YY

Signature of Authorized Organization Officer _____