THE FAMILY CRITICAL ILLNESS PLAN
SECONDARY APPLICANT ENROLLMENT FORM

CUNA CARIBBEAN INSURANCE
JAMAICA LTD.

SECTION 1: SECONDARYAPPLICANT INFORMATION

FIRST NAME | MIDDLE NAME | LAST NAME

DATE OF BIRTH (dd/mm/yyyy) | GENDER (M / F) | TRN NO. | ID TYPE & NO.

MOBILE NO. | OTHER TELEPHONE NO. | EMAIL ADDRESS

ADDRESS

PARISH/ CITY/STATE | COUNTRY OF BIRTH | COUNTRY OF RESIDENCE

OCCUPATION | SOURCE OF FUNDS | ACCOUNT #

ADMINISTRATOR | BRANCH

PRIMARY APPLICANT NAME (FIRST, LAST) | RELATIONSHIP TO PRIMARY APPLICANT

ADDITIONAL DUE DILIGENCE AND TAX RESIDENCY INFORMATION

1. Are you, or any of your immediate family[1] members or close associates, currently or have been within the last five years, a PEP* either locally or internationally? Yes ☐ No ☐
2. Details of Associated PEP (If applicable) - If you have indicated that you are a PEP or are associated with one, please provide the following details: Yes ☐ No ☐
   a. Full Name of PEP:
   b. Job Title/Position of PEP:
   c. Nature of relationship to PEP (if not yourself):
3. Do you hold citizenship/ nationality/ residency status or are required to file taxes in another country/ countries: 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 ☐

If your answer is yes to questions 3 or 4 above, please complete the Tax Residency Self Certification form. If your answer is 'No', please sign the applicant's declaration below.

SECONDARY APPLICANT'S DECLARATION

I, _____ , declare that I am not a citizen or tax resident of any country other than those listed on this form or the Tax Residency Self-Certification Form. I shall inform CUNA Caribbean Insurance Jamaica Limited (CCIJ) no later than sixty (60) days of any changes to the information provided in this form. I understand that I may be required to submit additional documentation to verify my tax status before a policy can be issued.

Signature of Secondary Applicant: _____ Date: _____ (dd/mm/yyyy)

***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.**

[1]Immediate family members include Spouse/Ex-spouse, parent, child/stepchild, sibling/half-sibling

NB: If you responded "Yes" to any of the questions above we will contact you to obtain additional information necessary to complete your application.

NB: A COPY OF PICTURE IDENTIFICATION (NATIONAL ID, DRIVERS PERMIT, PASSPORT), PROOF OF ADDRESS (UTILITY BILL OR BANK STATEMENT NOT OLDER THAN 3 MONTHS) AND THE FIRST MONTH'S PREMIUM MUST BE SUBMITTED WITH THIS ENROLLMENT. IF THE REQUIRED DOCUMENTS ARE NOT SUBMITTED, THE ENROLLMENT WILL BE PLACED ON HOLD AND NO COVERAGE WILL BE EFFECTED. WE MAY REQUEST ADDITIONAL DOCUMENTATION, IF NECESSARY, BEFORE ISSUING YOUR CERTIFICATE.

SECTION 2: SECONDARY APPLICANT MEDICAL QUESTIONS

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Have you ever been diagnosed with?

Cancer	Yes ☐	No ☐	Heart Attack	Yes ☐	No ☐	Coma	Yes ☐	No ☐
Paralysis	Yes ☐	No ☐	Major Burns	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐
HIV	Yes ☐	No ☐	Stroke	Yes ☐	No ☐	Heart Condition	Yes ☐	No ☐

2. Have you received, in the last 5 years, any medical attention, medical advice, surgical treatment or have been hospitalized? Yes ☐ No ☐

   If yes, please indicate the details _____

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SECTION 3: SECONDARY APPLICANT COVERAGE CHOICE

Age Bands (Years)	$500,000.00	$1,000,000.00	$1,500,000.00	$2,000,000.00	$2,500,000.00*	$3,000,000.00*
<35	$328.50 ☐	$657.00 ☐	$985.50 ☐	$1,314.00 ☐	$1,642.50 ☐	$1,971.00 ☐
35-44	$675.00 ☐	$1,350.00 ☐	$2,025.00 ☐	$2,700.00 ☐	$3,375.00 ☐	$4,050.00 ☐
45-54	$1,413.00 ☐	$2,826.00 ☐	$4,239.00 ☐	$5,652.00 ☐	$7,065.00 ☐	$8,478.00 ☐
55-59	$2,128.50 ☐	$4,257.00 ☐	$6,385.50 ☐	$8,514.00 ☐	$10,642.50 ☐	$12,771.00 ☐

***NB: THE PRIMARY APPLICANT CAN ONLY CHOOSE FROM THE FOUR (4) COVERAGE OPTIONS: $500,000 THROUGH TO $2,000,000 AT THE TIME OF INITIAL ENROLLMENT IN THE PLAN. AFTER INITIAL ENROLLMENT, THE PRIMARY APPLICANT MAY CHOOSE TO PURCHASE AN ADDITIONAL COVERAGE AMOUNT, FROM AMONG ALL SIX (6) COVERAGE BENEFIT OPTIONS, FOR HIMSELF AND EACH SUBSIDIARY INSURED.**

TERMS AND CONDITIONS OF SERVICE

The Family Critical Illness Plan: No person(s) may be insured through more than one Family Critical Illness Plan Policy in accordance with the Non-Duplication of Coverage clause contained in the Policy. If a person is named under more than one Family Critical Illness Plan Policy, on the death of such a person, the Insurer shall only be liable to pay one claim.

SECONDARY APPLICANT DECLARATION:

I also understand that WHERE I HAVE APPLIED FOR COVERAGE UNDER THE FAMILY CRITICAL ILLNESS PLAN, that there will be a six-month waiting period for the benefit under this application. Further I understand that if a claim is made under the Family Critical Illness Plan and a diagnosis is confirmed during the six-month 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 of the Insured's coverage.

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.

I agree that CUNA Caribbean Insurance Jamaica Limited may use all information contained in this application in order to augment and update its database, superseding all other information which CUNA Caribbean Insurance Jamaica Limited may have on record for me and my dependents in relation to any insurance product previously held with CUNA Caribbean Insurance Jamaica Limited.

DATA PROTECTION

CUNA Caribbean Insurance Jamaica Limited is 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, 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. The consents that we require to process your data are outlined below. Please review them carefully and if you agree, place a tick in the appropriate boxes, and sign at the space provided in acknowledgement of your agreement. If you do NOT agree with the "Mandatory" consents required to process the information provided on this application, please do NOT submit this application and destroy it to ensure the protection of the personal information contained herein.

MANDATORY CONSENT TO PROCESS DATA:

I hereby give my explicit consent for the collection, processing, use, and sharing of my personal data, including but not limited to my health data , and to the collection, processing, use and sharing of the personal data, including but not limited to the health data, of my dependents (being a minor, mental health patient or anyone of whom I am otherwise a legal representative), as is necessary for and pertaining to my or my dependent's insurance coverage, evaluation, payment of benefits and other matters related thereto by CUNA Caribbean Insurance Jamaica Limited, and where applicable the Administrator, for the purpose of risk assessment, underwriting, servicing my certificate, claims processing, compliance with legislative obligations under any law and for purposes of fraud prevention. I understand that this includes sharing my personal data with the regulatory authorities, reinsurers, and other third parties as required by law, as necessary for the administering of my certificate or fraud prevention.

OPTIONAL CONSENT:

I agree to receive direct communication from CUNA via written notice, SMS, email, etc. in relation to other products and services which may be offered by the company.

Yes ☐ No ☐

By signing this document, I confirm that I have read and understood the above information and provide consent where applicable.

Signature of Secondary Applicant: _____ Date: _____
dd/mm/yyyy

I hereby give my explicit consent for the addition of the Secondary Applicant, named above, to my Family Critical Illness Plan.

Signature of Primary Applicant: _____ Date: _____
dd/mm/yyyy

FOR OFFICIAL USE ONLY. To be completed by the Administrator

Application taken by: _____
Please Print Name

Date _____
dd/mm/yyyy