

# GOLDEN HARVEST SAVINGS PLAN ENROLLMENT FORM

## SECTION 1: APPLICANT INFORMATION

FIRST NAME	MIDDLE NAME	LAST NAME
<input type="text"/>	<input type="text"/>	<input type="text"/>
DATE OF BIRTH	GENDER	TRN NO.
<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="text"/>
<small>dd/mm/yyyy</small>		ID TYPE & NO.
<input type="text"/>		<input type="text"/>
MOBILE NO.	OTHER TELEPHONE NO.	EMAIL ADDRESS
<input type="text"/>	<input type="text"/>	<input type="text"/>
ADDRESS		
<input type="text"/>		
PARISH/ CITY/STATE	COUNTRY OF BIRTH	COUNTRY OF RESIDENCE
<input type="text"/>	<input type="text"/>	<input type="text"/>
OCCUPATION	SOURCE OF FUNDS	ACCOUNT #
<input type="text"/>	<input type="text"/>	<input type="text"/>
ADMINISTRATOR	BRANCH	
<input type="text"/>	<input type="text"/>	

## ADDITIONAL DUE DILIGENCE AND TAX RESIDENCY INFORMATION

- Are you, or any of your immediate family<sup>1</sup> members or close associates, currently or have been within the last five years, a PEP\* either locally or internationally? Yes  No
- 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 
  - Full Name of PEP:
  - Job Title/Position of PEP:
  - Nature of relationship to PEP (if not yourself):
- Do you hold citizenship/ nationality/ residency status or are required to file taxes in another country/ countries? Yes  No
- 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.

### 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 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.**

**<sup>1</sup>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) AND PROOF OF ADDRESS (UTILITY BILL OR BANK STATEMENT NOT OLDER THAN 3 MONTHS) MUST BE SUBMITTED WITH THIS ENROLLMENT . IF 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 COVERAGE.**

## SECTION 2: SAVINGS INFORMATION

Savings Goal \$ _____	Monthly Deposit Required \$ _____
Initial Deposit \$ _____	Term (in months) of Savings Contract \$ _____
Annual Interest Rate _____	

Within the last five years have you ever been treated for or been advised that you have any of the following conditions: diabetes, heart disorders, any cancer, acquired immune deficiency syndrome (AIDS), HIV infection or AIDS related complex? Yes  No

**(Answering Yes to the above question makes the applicant ineligible for insurance under the Golden Harvest Savings Plan.)**

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## SECTION 3: BENEFICIARY DETAILS

### DESIGNATION OF BENEFICIARY FOR THE APPLICANT

I hereby designate the following person as my Beneficiary for the Golden Harvest Savings Plan. My Beneficiary, if living, shall receive any and all sums of money, herein called the 'BENEFIT', paid under and by virtue of the terms and conditions of the Golden Harvest Savings Plan, of the CUNA Caribbean Insurance Jamaica Limited to the said Organization.

This designation takes precedence over any earlier designation wherever and however made. I hereby reserve the right to change the Beneficiary herein designated. If the designated beneficiary precedes me in death, the Benefit will be paid to my Estate

FIRST NAME

LAST NAME

AGE

RELATIONSHIP

CONTACT NO.

ADDRESS

Proportion:  100%  Other

If under 18, Please indicate Trustee's Name

I hereby authorize any physician or medical professional having information with respect to my physical or mental condition to furnish such information to CUNA Caribbean Insurance Jamaica Limited or its representative.

Signature of Applicant : \_\_\_\_\_

Date: \_\_\_\_\_  
dd/mm/yyyy

**If you wish to add additional beneficiaries, please complete a Designation of Beneficiary Form.**

### ABOUT THE GOLDEN HARVEST SAVINGS PLAN

- In the event you pass away or become totally and permanently disabled, your organisation will pay the total savings on your Golden Harvest Savings Plan account, plus insurance benefits (which equals your savings goal) to you, the insured, or your beneficiary.
- There is no minimum savings goal, and no minimum monthly deposit. The maximum savings goal insured is determined according to your needs and subject to the organisation's contract limit.
- All premiums will be paid to CUNA Caribbean Insurance Jamaica Limited by your organisation. If you discontinue the savings contract, all accumulated premiums paid by your organisation on your behalf may be deducted from your Golden Harvest Savings Plan account.
- Coverage becomes effective as soon as you sign the savings contract with the organization and pay your first deposit, the insurance coverage becomes effective.

### Coverage Terminates When:

- You cease to be a member of the organisation.
- You have not made a deposit for more than 60 days.
- You withdraw from the plan.
- Upon the date of maturity or when you have received the maturity value of the savings plan.
- You reach age 70.
- The organisation or CUNA Caribbean Insurance Jamaica Limited terminates the group contract.
- Your benefit is paid.

### Pre-existing Condition Clause:

This insurance will not pay death or total and permanent disability benefits due to an illness or injury for which you received medical advice, consultation or treatment within six (6) months prior to the effective date of the certificate. The pre-existing condition limitation will not apply if your death or total and permanent disability begins six (6) months or more after the effective date of the certificate.

### APPLICANT'S DECLARATION:

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 understand that if I fail to make the contracted monthly saving goal deposit on a timely basis the contract will be terminated and the total amount of any insurance premium paid on this contract by the Organization may be deducted from my accumulated savings balance to date.

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## 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](http://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, as is necessary for and pertaining to my 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 policy 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 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