REST FORM

FAMILY INDEMNITY PLAN
REINSTATEMENT REQUEST FORM

CUNA CARIBBEAN INSURANCE

SECTION 1: MEMBER INFORMATION

FIRST NAME

MIDDLE NAME

LAST NAME

DATE OF BIRTH

dd/mm/yyyy

GENDER M ☐ F ☐

IDENTIFICATION ☐ ID ☐ DP ☐ PP

ENTER ID NUMBER

MOBILE NO.

OTHER TELEPHONE NO.

EMAIL ADDRESS

MAILING ADDRESS

CITY

COUNTRY OF RESIDENCE

COUNTRY OF BIRTH

CERTIFICATE NO

ORGANISATION (Credit Union/FIP Provider)

NB: A COPY OF PICTURE IDENTIFICATION (PASSPORT, NATIONAL ID, DRIVERS PERMIT), BIRTH CERTIFICATE AND PROOF OF ADDRESS (UTILITY BILL OR BANK STATEMENT NOT OLDER THAN 3 MONTHS) MUST BE SUBMITTED WITH THIS APPLICATION. IF REQUIRED DOCUMENTS ARE NOT SUBMITTED APPLICATION WILL BE PLACED ON HOLD AND NO CHANGE TO COVERAGE WILL BE EFFECTED.

SECTION 2: TERMS OF REINSTATEMENT

DECLARATION:

CUNA Caribbean Insurance (CCI) reserves the right to decline any request for reinstatement of coverage at its sole discretion. I understand and agree that the decision to reinstate coverage is entirely at the discretion of CCI, and that CCI is under no obligation to reinstate coverage even if I have met all the requirements and paid any outstanding premium(s). In the event that coverage is reinstated, CCI reserves the right to impose any additional conditions or restrictions that it deems necessary to protect its interests. Any such conditions or restrictions shall be communicated by CCI in writing.

I understand, unless otherwise stated in the Policy, that no person may be covered under more than one certificate issued by CCI, and I have verified that all person(s) for whom reinstatement is/are requested are not covered under any other certificate. Where the person(s) being reinstated has been insured on another certificate underwritten by CCI during the time my certificate was terminated, the reinstatement for that person shall be denied and that person shall be removed from my certificate.

I declare that all person(s) covered under my terminated certificate number quoted above are alive at the time of my signing this application form and all persons are in good health. I understand that CCI may request a medical examination at my expense for any person listed on my certificate who is over the age of 75 at the date of this application and that reinstatement of coverage for those persons may not be approved until such medical reports have been supplied to CCI for review.

I agree to pay all outstanding premium(s) in the value of $_____ which will be delivered along with this application form and to continue to pay the premium on a monthly basis. I understand that failure to submit all outstanding premium(s) will result in denial of my request for reinstatement and the only recourse available to me would be a refund of such premium.

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 and if any of the statements made herein are fraudulently untrue or are material in relation to CCI's risk the insurance issued on the basis hereof shall be null and void.

I agree to be bound by the terms and conditions of the Family Indemnity Plan and continued payment of premiums to CCI and acceptance thereof constitutes my ongoing agreement. Yes ☐ No ☐

I agree to receive direct communication from CCI via written notice and electronic means including SMS, WhatsApp or email. about information pertaining to my insurance coverage. Yes ☐ No ☐

I agree to receive direct communication from CCI via written notice and electronic means including SMS WhatsApp or email in relation to other products and services which may be offered by the company. Yes ☐ No ☐

Applicant's Consent to Processing of Personal Information:

I consent to CCI and where applicable, the Administrator, accessing and further processing my personal data, the personal data of my dependents and other information required for and pertaining to my insurance coverage, evaluation, payment of benefits and matters related thereto. Yes ☐ No ☐

NB: If you do not consent to the processing of the personal information supplied on this form, please do not submit this application and destroy this application to ensure protection of the personal information contained herein.

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

Signature of Policyowner: _____

Date: _____

dd/mm/yyyy