CUNA CARIBBEAN INSURANCE JAMAICA LTD.

THE FAMILY INDEMNITY PLAN

CHANGE OF INSURED FORM

Policyholder Name ____

Policy No. ____________________ Account/Reference No. ____________________

Policyholder Address ____

E-mail ______________________________________ Cell No. ________-__________

Administrator ____________________________ Branch ____________________

This Change of Insured shall be effective on the first day of the month following the date the Policyholder signs this form.

The Policyholder may name a new or replacement Insured Person upon the occurrence of the following events, in accordance with the policy. Please tick the event that applies:

☐ Divorce of the Policyholder ☐ Marriage of Child ☐ Child has reached age 26

☐ Death of an Insured Party ☐ Transfer ☐ New

☐ Other (subject to approval by CCIJ)

If you do not inform **CUNA Caribbean Insurance Jamaica Limited (CCIJ)** via the Administrator of the occurrence of the selected event within 30 days, there will be a **six (6) month waiting period** for benefits due to natural death for the newly approved insured party. The six- month waiting period is waived for Accidental death benefits.

PERSON BEING DELETED

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

PERSON BEING ADDED

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

Coverage will cease for the person being deleted from the plan. If the person being added is a replacement the six (6) month waiting period does not apply. At no time may more than six (6) persons be insured under one Policy.

No person may be insured on more than one Family Indemnity Plan in accordance with the Non-Duplication of Coverage clause. If a person is named under more than one Family Indemnity Plan, on the death of such a person, the Insurer shall only be liable to pay one claim.

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

Signature of Policyholder: ______________________________ Date: ______/_____/_______
DD / MM / YYYY

Signature of Administrator's Representative: __________________________