Enrollment #		*Insert member's name who referred you to the "FBI" Plan*	
Circle to Indicate if Enrollment is NEW or a Transition from another provider.		*NEW*	*TRANSITION*

Family Bereavement Insurance - "FBI"

Member Enrollment Form

Print your NAME, DATE OF BIRTH, AGE and the relationship of all individuals you wish to include in this plan.

	LAST NAME	FIRST NAME	MIDDLE NAME	AGE	SEX	DATE OF BIRTH DAY	DATE OF BIRTH MONTH	DATE OF BIRTH YEAR	RELATIONSHIP TO MEMBER
1									Primary
2									
3									
4									
5									
6									

Provide copy of Passport OR Birth Certificate as proof of Identification for Primary and other insured persons listed, together with copy of Marriage Certificate where ever applicable.

We reserve the right to request additional proof of Identification of the above persons listed for coverage

Member Account Number: _____ Name of Credit Union: _____

CICL Certificate # _____ Cooperative Credit Union Ltd

Branch: _____

Member"s Address: _____ Contact Number: _____

Email Address: _____

Monthly Premium	$75	$60	$50	$35	$25	$15
Indicate the plan	□ Plan A	□ Plan B	□ Plan C	□ Plan D	□ Plan E	□ Plan F
Benefits to Plans	$15,000	$12,000	$10,000	$8,000	$5,000	$3,500

Are you or any person named above presently covered under another plan? □ Yes □ No

Under this plan, each member (Policy Holder) can enroll five (5) additional family members. Consideration for inclusion are as follows: Spouse/Significant Other, Divorced Spouse, Children including dependant Children under the age of 25 years, Disabled Children under 26yrs, two parents and or In-Laws. It is the sole responsibility of the member to ensure that the persons listed are not part of any other plan. Dual coverage is not permitted under the Family Bereavement Insurance policy. If a person enlisted under more than one plan, only one claim will be settled by Corp-EFF Insurance Company Ltd. "CICL"

I understand that members who are part of an existing plan endorsed by the Credit Union, will be rolled over to the Family Bereavement Insurance and there shall be NO WAITING period for submission of claims. I further understand that new members will be subject to a six months waiting period, during which time NO CLAIM will be payable for death which occurs as a result of natural causes. During the six months waiting period only accidental death benefits will be paid.

I fully understand that to the best of my knowledge and belief, all statements contained in this enrollment are true and agree that if there is any evasion, concealment or misrepresentation in any of the statements made therein, the insurance issued on the basis hereof shall be null and void.

I have read and understood the above information. In confirmation of this, I have signed and dated this document.

PLEASE COMPLETE A DESIGNATION OF BENEFICIARY & AUTOMATIC DEDUCTION FORM TO ACCOMPANY THIS ENROLLMENT.

Date: _____

Member's Signature _____ _____

PRINT NAME **MEMBER'S SIGNATURE**

Witnessed by Credit Union Rep: _____ _____

PRINT NAME **WITNESS SIGNATURE**

_____

DESIGNATION & DATE

For Internal Use Only

Checked By CICL Rep: _____ _____

SIGNATURE **DESIGNATION & DATE**

Certified by CICL Rep: _____ _____

SIGNATURE **DESIGNATION & DATE**

Approved by CICL Rep: _____ _____

SIGNATURE **DESIGNATION & DATE**

***Premium rates are subject to change. All benefits and provisions are subject to the terms and conditions of the policy which is available at your institutions.**