CUNA CARIBBEAN
INSURANCE

Family Critical Illness Plan

ADDITION OF COVERAGE

Please write in BLOCK letters and in the Designated Spaces, Mark all choice boxes with a X and NOT with a tick (✓).

This Change of Coverage shall be effective on the first day of the month following the date the undersigned Insured delivers this form to the organization and the associated first month's premium is received by your organization.

Organization ____

Certificate Number __________________________ **Membership Number** ____

Primary Insured Member's Name (First/Last Name) ____

Proof of Age Submitted: Birth Certificate [ ] Driver's License [ ] Passport [ ] ID Card [ ]

Please answer the following questions:

1. Have you or the Insured Person ever been treated or diagnosed with Cancer, Heart Attack, Stroke, Paralysis, Major Burns, Coma, HIV, Heart Condition or Diabetes? YES ( ) NO ( )

1b. If yes, please indicate which condition above ____

2. Have you or the Insured Person received, in the last five (5) years, any medical attention or advice or surgical treatment or been hospitalized? YES ( ) NO ( )

2b. If yes, please indicate the details ____

Benefits under this Policy are not payable if the diagnosis of a Critical Illness covered results either directly or indirectly from AIDS or HIV virus during the five years of continuous coverage immediately following the effective date of enrolment

We will not pay a benefit if an Insured Person is diagnosed with a Critical Illness caused either directly or indirectly from any disease, health condition or bodily injury for which the Insured Person received medical advice, consultation, diagnosis or treatment prior to the Effective Date of the Plan for the Insured Person and which disease, health condition or bodily injury was known to the Insured Person and/or the Primary Insured and was not fully and truthfully disclosed to us prior to the Effective Date of coverage.

BENEFIT INFORMATION

1. The monthly premium payable for the Insured Person is based on the issue age and the selected coverage limit.
2. The maximum enrollment age is 59 years up to and including day before the 60th birthday and 25 years in the case of the Primary Insured's unmarried children.
3. Termination age is 26 years for the Primary Insured's unmarried children who are not permanently disabled and 75 years for all others.
4. The premium amount payable for each coverage amount applied for remains the same for that coverage amount throughout the lifetime of the certificate for each Insured Person
   The Primary Insured will be required to collect the benefit for all Insured Persons if the Primary Insured is living and not medically unable to do so

PLEASE INDICATE Total CURRENT Premium: ___________________ **(For all Insured Persons on the Certificate)**

Please Indicate ADDITIONAL Coverage being selected for the Primary Insured and associated premium due. *Total Coverage for an Insured Person cannot exceed $300,000.00.* At no time should the coverage amount for each additional Insured Person be greater that the coverage amount of the Primary Insured.

Coverage Option - Primary Insured Monthly Premium Per Person										
Age Band (years)	**$50,000**		**$100,000**		**150,000**		**$200,000**		**$250,000**	
<35	☐	**$ 36.50**	☐	**$ 73.00**	☐	**$ 109.50**	☐	**$ 146.00**	☐	**$ 182.50**
35-44	☐	**$ 75.00**	☐	**$ 150.00**	☐	**$ 225.00**	☐	**$ 300.00**	☐	**$ 375.00**
45-54	☐	**$ 157.00**	☐	**$ 314.00**	☐	**$ 471.00**	☐	**$ 628.00**	☐	**$ 785.00**
55-59	☐	**$ 236.50**	☐	**$ 473.00**	☐	**$ 709.50**	☐	**$ 946.00**	☐	**$ 1,182.50**

New Coverage amount is: $__________________

Primary Insured Premium Due for Additional Coverage: $________________

PRIMARY INSURED'S SIGNATURE___________________________ **MM / DD / YY** ______/_______/________

Additional Insured Person(s) Premium Due

Only applicable if change is requested for an additional Insured person. Please complete table below based on Appendix 1 form

Additional Insured's Name	Relationship to Primary Insured	Coverage Amount	Premium Due
1			
2			
3			
4			
5			

Total Additional Insured Premium Due for Additional Coverage:

Total Premium Due to be Paid: ___________________ ***Total Current Premium + Primary Insured Premium Due (if applicable) + Total Additional Insured Premium Due (if applicable)***

Date Paid: MM / DD / YY _______/________/_________

I understand that If an Insured Person is diagnosed within six (6) months of the date of change of Coverage Option, We will pay Benefits based on the lower Coverage Option, unless diagnosis results from an accident

I further understand that starting with the Effective Date of Change, the premium I will pay will be greater due to the increase in coverage under the new plan.

____

Signature of the Primary Insured Member

Date

☐☐ ☐☐ ☐☐☐☐

mm dd yyyy

____

Signature of Authorized Organization Officer

Date

☐☐ ☐☐ ☐☐☐☐

mm dd yyyy

CUNA CARIBBEAN
INSURANCE

Family Critical Illness Plan

ADDITION OF COVERAGE

Appendix 1

Please complete for change being requested for EACH additional Insured Person

Additional Insured's Name (First/Last Name) ____

Relationship to Primary Insured ______________________________

Proof of Age Submitted: Birth Certificate [ ] Driver's License [ ] Passport [ ] ID Card [ ]

Please answer the following questions:

1. Have you or the Insured Person ever been treated or diagnosed with cancer, Heart Attack, Stroke, Paralysis, Major Burns, Coma, HIV, heart condition or diabetes? YES ( ) NO ( )

1b. If yes, please indicate which condition above ______________________________________

2. Have you or the Insured Person received, in the last five (5) years, any medical attention or advice or surgical treatment or been hospitalized? YES ( ) NO ( )

2b. If yes, please indicate the details ______________________________________

Benefits under this Policy are not payable if the diagnosis of a Critical Illness covered results either directly or indirectly from AIDS or HIV virus during the five years of continuous coverage immediately following the effective date of enrolment

We will not pay a benefit if an Insured Person is diagnosed with a Critical Illness caused either directly or indirectly from any disease, health condition or bodily injury for which the Insured Person received medical advice, consultation, diagnosis or treatment prior to the Effective Date of the Plan for the Insured Person and which disease, health condition or bodily injury was known to the Insured Person and/or the Primary Insured and was not fully and truthfully disclosed to us prior to the Effective Date of coverage.

BENEFIT INFORMATION

1. The monthly premium payable for the Insured Person is based on the issue age and the selected coverage limit.
2. The maximum enrollment age is 59 years up to and including day before the 60th birthday and 25 years in the case of the Primary Insured's unmarried children.
3. Termination age is 26 years for the Primary Insured's unmarried children who are not permanently disabled and 75 years for all others.
4. The premium amount payable for each coverage amount applied for remains the same for that coverage amount throughout the lifetime of the certificate for each Insured Person

Please Indicate ADDITIONAL Coverage being selected for the Additional Insured and associated premium due: *Total Coverage for an Insured Person cannot exceed $300,000.00*. At no time should the coverage amount for each additional Insured Person be greater that the coverage amount of the Primary Insured.

Coverage Option - Additional Insured

Monthly Premium Per Person

Age Band (years)	$50,000		$100,000		150,000		$200,000		$250,000	
<35	☐	$ 32.85	☐	$ 65.70	☐	$ 98.55	☐	$ 131.40	☐	$ 164.25
35-44	☐	$ 67.50	☐	$ 135.00	☐	$ 202.50	☐	$ 270.00	☐	$ 337.50
45-54	☐	$ 141.30	☐	$ 282.60	☐	$ 423.90	☐	$ 565.20	☐	$ 706.50
55-59	☐	$ 212.85	☐	$ 425.70	☐	$ 638.55	☐	$ 851.40	☐	$ 1,064.25

Additional Insured Premium Due for Additional Coverage: ____________________ ***Total Coverage for an Insured Person cannot exceed $300,000.00***

I understand that If an Insured Person is diagnosed within six (6) months of the date of change of Coverage Option, We will pay Benefits based on the lower Coverage Option, unless the diagnosis results from an accident

I further understand that starting with the Effective Date of Change, the premium I will pay will be greater due to the increase in coverage under the new plan.

____
Signature of Primary Insured Member

Date

mm dd yyyy

____
Signature of Authorized Organization Office

Date

mm dd yyyy