For Official Use Only

CUNA CARIBBEAN INSURANCE

The Family Indemnity Plan

CHANGE OF PLAN

Please write in BLOCK letters and WITHIN THE BOXES, AVOIDING CONTACT WITH THE EDGE OF THE BOX 1 2 3 4.

This Change of Plan shall be effective on the first day of the month following the date the Insured delivers this form to and is received by your organisation.

Organisation

Certificate Number

Membership Number

Member Name (First/Last Name)

Current Plan

Current Benefit Amount

New Plan

New Benefit Amount

Effective Date of Change

mm dd *yyyy*

New Premium Due

Date Paid

mm dd *yyyy*

I understand that there will be a six (6) month waiting period for the higher benfit under this change of plan. I also understand that if a claim is incurred during the six month waiting period, the claim benefit will be based on the original plan (except in the case of accidental death).

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 Member

Signature of Authorised Organisation Officer

Date

mm dd *yyyy*