

For Official Use Only

Three empty boxes for official use.

The Family Indemnity Plan

MEMBER ENROLLMENT FORM

Please write in BLOCK letters and WITHIN THE BOXES, AVOIDING CONTACT WITH THE EDGE OF THE BOX 1 2 3 4; mark all choice boxes with an X and NOT with a tick (✓)

- 1. Have you previously had a Family Indemnity Plan certificate? Yes No
- 2. Are you or any person(s) who will be listed below presently covered under another Family Indemnity Plan? Yes No
- 3. Open Enrollment Period Applicable? Yes No From _____ To _____

Organisation

Large grid for Organisation name.

Membership No

Telephone No

Street

City

Country

Please complete a Designation of Beneficiary Form if you are the only person on this form or if all insureds are minors.

NAME(First Name/Last Name)	DATE OF BIRTH			SEX	RELATIONSHIP TO MEMBER
	MM	DD	YYYY		
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	
				<input type="checkbox"/> M <input type="checkbox"/> F	

Plan Selected Benefit Amount _____

I acknowledge that I have read and understood the Terms & Conditions of Service on the reverse side of the form.

Please include the premium payment along with this Enrollment Form.

Amt. Paid _____
Date Paid mm - dd - yyyy

Signature of Member

Signature of Authorised Organisation Officer

Date Signed By Authorised Organisation Officer



TERMS AND CONDITIONS OF SERVICE

1. We reserve the right to request proof of all information. The effective date of your Certificate will always be the first of the month following enrollment.
2. If enrolling for Family Indemnity Plan coverage outside of the "Open Enrollment Period" You, the member, along with the other Insured Persons will be subject to a Six Months Waiting Period before full coverage begins. During the Six Months Waiting Period only accidental death benefits are covered.
3. **It is the sole responsibility of the Member to ensure that eligible persons for whom application is being made, are not insured persons who have existing coverage under The Family Indemnity Plan as no person may be insured through more than one Family Indemnity Plan Certificate in accordance with the Non-Duplication of Coverage clause contained in the Member's Family Indemnity Plan Certificate. If a person is named under more than one Family Indemnity Plan Certificate, on the death of such a person the Insurer shall only be liable to pay the claim made under The Family Indemnity Certificate that is first in time.**
4. I understand and certify 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 herein, the insurance issued on the basis hereof shall be null and void.
5. Premium rates are based upon the experience of the Plan and shall be reviewed annually and may be changed no more than once a year. If We change the premium rate, We will give you thirty-one (31) days advance written notice.
6. By signing this document you are confirming that you have read and understood the above information.