RESET FORM

FAMILY INDEMNITY PLAN CLAIM FORM

CUNA CARIBBEAN INSURANCE

SECTION 1: BENEFICIARY INFORMATION

Please check appropriate box: I am the Insured Member: ☐ Beneficiary: ☐ Other: ☐ _____ Please State

FIRST NAME | MIDDLE NAME | LAST NAME

DATE OF BIRTH (dd/mm/yyyy) | GENDER M ☐ F ☐ | IDENTIFICATION ☐ ID ☐ DP ☐ PP | ENTER ID NUMBER

MOBILE NO. | OTHER TELEPHONE NO. | EMAIL ADDRESS

MAILING ADDRESS

CITY | COUNTRY OF RESIDENCE | COUNTRY OF BIRTH

CERTIFICATE NUMBER | ORGANISATION (Credit Union / FIP Provider) | RELATIONSHIP TO DECEASED

I the undersigned, hereby certify that the information contained in this document is true and correct and make claim to the Insurance as Beneficiary and agree the furnishing of this form or any supplemental forms shall not be considered an admission of insurance coverage by CUNA Caribbean Insurance nor a waiver of any of its rights or defenses. I acknowledge that any information which I have supplied which is knowingly false will result in denial of claim and such statement may be referred to relevant authorities for investigation and can be used as part of criminal proceedings that those authorities see fit.

Signature: _____ Date: _____ dd/mm/yyyy

SECTION 2: TO BE COMPLETED FOR DEATH CLAIM

Name of Deceased:

Date of Birth: (dd/mm/yyyy) | ID ☐ DP ☐ PP ☐ | ENTER ID NUMBER

Death Due To: Accident ☐ Suicide ☐ Homicide ☐ Natural Causes ☐

Date of Death: (dd/mm/yyyy) | Cause of Death:

REQUIRED DOCUMENTATION: Death Certificate and Identification for Deceased must be submitted for Claims Processing. Failure to submit at time of claim, will result in delay in claim processing and any potential payment

SECTION 3: TO BE COMPLETED FOR OTHER CLAIMS

Please check box next to type of claim: Terminal Illness ☐ Critical Illness: ☐

Date of Diagnosis: dd/mm/yyyy

Name of Condition

Cause of Diagnosis

Name of Attending Physician

Address of Attending Physician

Telephone Number of Attending Physician

I hereby authorise any licensed Physician, Medical Practioner, Hospital, Clinic or any other medically related facility , insurance company, Medical Information Bureau or an other organisation or person that has any records or knowledge of my health in relation to the condition stated above to release any such information to CUNA Caribbean Insurance for the purpose of processing this claim

Signature: _____ Date: _____ dd/mm/yyyy

FAMILY INDEMNITY PLAN
CLAIM FORM

CUNA CARIBBEAN INSURANCE

REQUIRED DOCUMENTATION:

1) For claims related to Terminal Illness, please ensure that the Physician's Criticial Illness Report is completed and submitted along with this Claim Form
2) For claims related to Critical Illness, please ensure that the Physician's Critical Illness Report is completed and submitted along with this Claim Form
3) A valid form of Identification and Proof of Address for the Insured must be submitted with this Claim Form

SECTION 4: POLICE REPORT (To be completed by the Police for Homicide cases)

Reporting Officer

Report Date

dd/mm/yyyy

Police Station

Details of Incident

PHYSICIAN'S CRITICAL ILLNESS STATEMENT

CUNA CARIBBEAN INSURANCE

PLEASE COMPLETE THE BELOW IN BLOCK LETTERS

FIRST NAME | MIDDLE NAME | LAST NAME

DATE OF BIRTH
dd/mm/yyyy

DIAGNOSED ILLNESS OR INJURY

DESCRIPTION OF ILLNESS OR INJURY

DATE SYMPTOMS FIRST APPEARED (dd/mm/yyyy) | DATE OF FIRST CONSULTATION (dd/mm/yyyy)

PRINCIPAL CAUSE OF ILLNESS OR INJURY | DATE OF ONSET (dd/mm/yyyy)

CONTRIBUTING CAUSE 1 | DATE OF ONSET (dd/mm/yyyy)

CONTRIBUTING CAUSE 2 | DATE OF ONSET (dd/mm/yyyy)

Is HIV Infection or AIDS related complex a contributory cause? Yes ☐ No ☐

Is Injury or Sickness due to an accident? Yes ☐ No ☐

DATES OF TREATMENT

Office dd/mm/yyyy

Home dd/mm/yyyy

Hospital dd/mm/yyyy

Types of Tests Performed (MRI/CT/PET/Labs etc.)

NB: Results of any investigative tests and/or medical reports in support of diagnoses to be submitted along with this document

If patient is/was hospitalized, give name and address of hospital:

Name of Hospital	Address	Date Admitted dd/mm/yyyy	Date Discharged dd/mm/yyyy

I HEREBY CERTIFY THAT I ATTENDED TO THE PATIENT AND SICKNESS / INJURY OCCURRED FROM THE CAUSES LISTED ABOVE

Physician's Stamp

Signature of Physician: _____