RESET FORM

# FAMILY INDEMNITY PLAN
# DESIGNATION/REVOCATION OF BENEFICIARY FORM

CUNA CARIBBEAN INSURANCE

## A. DESIGNATION OF BENEFICIARY (PLEASE COMPLETE IF NAMING A NEW BENEFICIARY)

I _____being the Policyowner hereby designate the following person(s) to receive benefits on Policy/Certificate No. _____which may be issued on acceptance of application.

**BENEFICIARY (1):** Percentage to be paid (___ %)

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

RELATIONSHIP TO INSURED

☐ IRREVOCABLE ☐ REVOCABLE

**BENEFICIARY (2):** Percentage to be paid (___ %)

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

RELATIONSHIP TO INSURED

☐ IRREVOCABLE ☑ REVOCABLE

**BENEFICIARY (3):** Percentage to be paid (___ %)

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

RELATIONSHIP TO INSURED

☐ IRREVOCABLE ☐ REVOCABLE

**TRUSTEE**

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

RELATIONSHIP TO INSURED

# FAMILY INDEMNITY PLAN
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CUNA CARIBBEAN INSURANCE

## B. REVOCATION OF DESIGNATED BENEFICIARY
## (PLEASE COMPLETE IF REMOVING A PREVIOUSLY NAMED BENEFICIARY AND IS PERMISSIBLE BY LAW).

I _____ hereby revoke the persons listed below as beneficiaries in respect of Policy/Certificate No. _____

**BENEFICIARY (1)**

FIRST NAME | MIDDLE NAME | LAST NAME

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

**BENEFICIARY (2)**

FIRST NAME | MIDDLE NAME | LAST NAME

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

**BENEFICIARY (3)**

FIRST NAME | MIDDLE NAME | LAST NAME

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

**TRUSTEE**

FIRST NAME | MIDDLE NAME | LAST NAME

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

Unless otherwise expressly provided herein, if two or more persons are designated beneficiaries the proceeds of the policy will be shared equally.

Where one or more revocable beneficiaries dies before the Policyowner/Insured Member, the Policyowner/Insured Member may replace such beneficiary by a Declaration.

A Declaration shall not be valid unless received by CUNA Caribbean Insurance at our registered office at Savannah East, Third Floor, 11 Queen's Park East, Port of Spain

Subject always to any written law (including any restriction or prohibition therein) or order of a court of competent jurisdiction, an irrevocable beneficiary may only be revoked or altered with the written consent of the irrevocable beneficiary.

**Applicant's Consent to Processing of Personal Information:**

I consent to CUNA and where applicable, the Administrator, accessing and further processing my personal data, the personal data of my dependents and other information required for and pertaining to my insurance coverage, evaluation, payment of benefits and matters related thereto. Yes ☐ No ☐

NB: If you do not consent to the processing of the personal information supplied on this form, please do not submit this application and destroy this application to ensure protection of the personal information contained herein.

By signing this document, I confirm that I have read and understood the above information.

Primary Insured Signature: _____ Date: _____ dd/mm/yyyy

**CONSENT OF IRREVOCABLE BENEFICIARY**

I hereby consent to my removal as a beneficiary of my own free will and hereby relinquish all of my rights, title and interest in the above referenced insurance policy.

[For spouses/trustees]] I hereby consent to my removal as a beneficiary and hereby relinquish all of my rights, title and interest in the above referenced insurance policy. I confirm that I have obtained independent legal advice, that I understand the implications of giving this consent and that my consent is freely given.

Name: _____

Identification: _____

Signature: _____Date: _____ dd/mm/yyyy

Witness: _____

Identification: _____

Relationship to the Insured _____

## C. DATE RECEIVED BY CUNA CARIBBEAN INSURANCE

Date: _____ dd/mm/yyyy Name/Position: _____