CUNA CARIBBEAN INSURANCE
JAMAICA LTD.

THE FAMILY INDEMNITY PLAN

CHANGE OF PLAN FORM

This Change of Plan shall be effective on the first day of the month following the date the Insured signs this form and it is received by the Organization.

Insured's Name _____

Certificate No. _____ Membership/Account No. _____

Address of Insured _____

E-mail _____ Cell No. _____-_____

Organization _____

Current Plan	
☐	A
☐	B
☐	C
☐	D
☐	E
☐	F

Select **New** Plan	
☐	B
☐	C
☐	D
☐	E
☐	F
☐	G

I understand that there will be a six-month waiting period for the higher benefit 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 Insured _____ Date____/_____/_____
DD / MM / YYYY

_____ _____
Plan Change Taken By: (PRINT NAME OF STAFF) Signature of Authorized Organization Officer