

**The Family Indemnity Plan Member Enrollment Form**

**PLEASE WRITE CLEARLY:** Indicate the complete name, date of birth, age and the relationship of all individuals enrolling in the plan including yourself.

Name of Credit Union \_\_\_\_\_ Open Enrollment Period  Yes  No From \_\_\_\_\_ To \_\_\_\_\_

The effective date of your Certificate will always be the first of the month following enrollment.

If enrolling for the 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.

NAME: LAST	FIRST	MIDDLE	DATE OF BIRTH		AGE	SEX	RELATIONSHIP TO MEMBER
			MONTH	DAY			
1.							MEMBER
2.							
3.							
4.							
5.							
6.							

Address \_\_\_\_\_ Telephone No \_\_\_\_\_

My membership No. \_\_\_\_\_ Plan selected:  Plan A  Plan B  Plan C  Plan D  Amount of Benefit: \$ \_\_\_\_\_

- 1. Have you previously had a Family Indemnity Plan certificate?  Yes  No
- 2. Are you or any person named above presently covered under another Family Indemnity Plan?  Yes  No

**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 Members 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.**

**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.**

**PLEASE COMPLETE A DESIGNATION OF BENEFICIARY FORM IF YOU ARE THE ONLY INSURED PERSON .**

I have read and understood the above information. In confirmation of this I have signed and dated this document.

Members Signature \_\_\_\_\_ Date \_\_\_\_\_ (Month) \_\_\_\_\_ (Day) \_\_\_\_\_ (Year)

Please include the premium payment along with this Enrollment Form.

Amt. Paid \_\_\_\_\_ Receipt No. \_\_\_\_\_ Date Paid \_\_\_\_\_ mm/dd/yy