

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	GENDER	IDENTIFICATION
	M ☐ F ☐	
dd/mm/yyyy		ID DP PP
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:		ID ☐ DP ☐ PP ☐	
	dd/mm/yyyy		ENTER ID NUMBER
Death Due To:	Accident ☐	Suicide ☐	Homicide ☐ Natural Causes ☐
Date of Death:		Cause of Death:	
	dd/mm/yyyy		

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

REQUIRED DOCUMENTATION:

- 1) For claims related to Terminal Illness, please ensure that the Physician's Critical 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



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

Signature of Physician: _____

Physician's Stamp