

## THE FAMILY INDEMNITY PLAN CHANGE OF INSURED FORM

Insured's Name \_\_\_\_\_

Certificate No. \_\_\_\_\_ Membership/Account No. \_\_\_\_\_

Organization \_\_\_\_\_

**This Change of Insured shall be effective on the first day of the month following the date the member signs this form** and delivers it to the Organization through which he/she holds his/her certificate and the Organization files the Change of Insured form with the office administering the plan.

You must inform the Organization within 30 days of any change. If you do not inform the Organization of a change within 30 days, there will be a **six (6) month waiting period** for benefits due to natural death (accidental death benefits will be paid).

**At no time may more than six (6) persons be insured under one certificate.**

Check the situation which applies:

- Divorce of the Member     
  Child has reached age 1     
  Child has reached age 26  
 Re-marriage of Member     
  Death of an Insured     
  Other \_\_\_\_\_

### PERSON BEING DELETED

LAST NAME	FIRST NAME	DATE OF BIRTH DD / MM / YY	AGE	SEX	RELATIONSHIP TO MEMBER

**OR**

### PERSON BEING ADDED

LAST NAME	FIRST NAME	DATE OF BIRTH DD / MM / YY	AGE	SEX	RELATIONSHIP TO MEMBER

**I understand that there will no longer be any coverage for the person being deleted from the plan. The person being added will be a new insured under the plan.**

**It is the sole responsibility of the Member to ensure that eligible persons for whom application is being made are not persons who have existing coverage under The Family Indemnity Plan at any Organization/Institution. 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 Family Indemnity Plan Policy. 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 one claim.**

Signature of Insured \_\_\_\_\_

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
DD / MM / YY

Signature of Authorized Organization Officer \_\_\_\_\_