The GOLDEN HARVEST Savings Plan

CUNA CARIBBEAN INSURANCE

MEMBER ENROLMENT FORM

Date of Enrolment in Golden Harvest Savings Plan _____
Month Day Year

Name _____
First Middle Last

Address _____
Street City Country

Telephone _____ Date of Birth _____ Age _____
Month Day Year

☐ Male ☐ Female

Policyholder Name _____ Date of Membership _____
Month Day Year

Membership Number _____

Designated Beneficiary _____ Relationship to you _____
First Name Last Name

Golden Harvest Savings Plan Contract

Savings Goal _____ Monthly Deposit Required _____

Term (in months) of Savings Contract _____ Annual Interest Rate _____

1. (a) **In the last five (5) years have you received any medical attention, advice, surgical procedure or been treated for any illness?** Please tick the appropriate response. ☐ **Yes** ☐ **No**

   (b) If **yes**, please provide details: _____

   _____

(Answering Yes to the above question makes the applicant subjected to underwriting approval)
I understand that if I fail to make the contracted monthly savings goal deposits on a timely basis the contract will terminate, and the total amount of any insurance premiums paid on this contract by the Policyholder may be deducted from my accumulated savings balance to date.

I have provided the above information and acknowledge all statements to be correct to the best of my knowledge. I am in good health at this time.

Member's Signature _____ Date _____
Month Day Year

To be completed by Policyholder Personnel

Enrolment taken by: _____ Signature: _____
(Print Name)

Insurance Coverage approved by: _____ Signature: _____
(Print Name)

Insurance Coverage Effective Date _____ Golden Harvest Savings Plan Account Number Assigned: _____
(Month Day Year)