



F.I.P. CLAIM FORM

Please select your branch Port of Spain Arima Chaguanas San Fernando Tobago

BENEFICIARY / POLICY HOLDER INFORMATION

Surname: _____ First Name: _____

Residential Address: _____

Mailing Address: _____

(If different from above):

Date of Birth: _____ ID type: National ID Driver permit Passport ID number: _____
(day/month/year)

Cell: _____ Home: _____ Work: _____ Ext _____

Email: _____

Beneficiary or Policy holder Signature: _____ Date: _____

DECEASED INFORMATION

Surname: _____ First Name: _____

Residential Address: _____

Mailing Address: _____

(If different from above):

Date of Birth: _____ ID type: National ID Driver permit Passport ID number: _____
(day/month/year)

Date of Death: _____
(day/month/year)

FOR OFFICIAL USE ONLY

Account Number: _____

F.I.P. Certificate Number: _____

Premium Plan: _____

Premium Amount (\$): _____

Benefit Amount (\$): _____

Months in Arrears: _____ Arrears Amount (\$): _____

Balance on Account (\$): _____

DOCUMENTS ATTACHED

- CUNA Explanation of Benefits
- CUNA Claim Statement Form
- Copy of death certificate
- Copy of valid ID cards (Claimant and deceased)

Date Received: _____ Received By: _____

Checked By: _____ Date Checked By: _____

C.E.O / OM: _____ Date: _____