TIP Friendly Society
Upgrading & Change Form

This application form exists solely for existing members to make the necessary names and address changes and/or adjustments to their insurance, investments or loans options. Please fill out application form completely and accurately. Write not applicable (N/A) in areas that do not apply. Coverage terminates at retirement or age seventy (70), whichever comes first. Kindly notify our offices when you or your spouse attains this. ***This form applies to existing members only***.

☐ **Policy Upgrade** ☐ **Reallocation** ☐ **Loan(s) Increase** ☐ **Name Changes** ☐ **Removal/Addition**

MEMBER INFORMATION IF THERE IS A NAME CHANGE FOR THE MEMBER, DOCUMENTED EVIDENCE REGARDING THIS SHOULD BE SUBMITTED, SUCH AS A DEED POLL OR A MARRIAGE CERTIFICATE.		
Date:	Member No:	T.R.N.:
☐ Miss ☐ Ms. ☐ Mr. ☐ Mrs.	Name:	
Date of Birth (D/M/Y):	Phone:	
Current Address:		
	E-Mail:	
EMPLOYMENT INFORMATION		
Place of Work:	School Code:	
Work Address:		
	Phone:	
Occupation:	☐ Full-time ☐ Part-time ☐ Temporary	
Annual Salary:	Length of Employment:	
SPOUSE'S INFORMATION (ONLY IF INCLUDED FOR COVERAGE)		
Name:	Address:	
	E-Mail:	
Phone:	Date of Birth (D/M/Y):	
Occupation:	☐ Full-time ☐ Part-time ☐ Temporary	Annual Salary:
CHILDREN (ONLY IF INCLUDED FOR COVERAGE)		
Name:	Relationship:	Date of Birth (D/M/Y):
Name:	Relationship:	Date of Birth (D/M/Y):
Name:	Relationship:	Date of Birth (D/M/Y):
Name:	Relationship:	Date of Birth (D/M/Y):
FAMILY INFORMATION (ONLY IF INSURED)		
Name of Member:		
Name:	Relationship:	Date of Birth (D/M/Y):
Name:	Relationship:	Date of Birth (D/M/Y):
Name:	Relationship:	Date of Birth (D/M/Y):
Name:	Relationship:	Date of Birth (D/M/Y):
Name:	Relationship:	Date of Birth (D/M/Y):

BENEFICIARIES **Please state beneficiaries who will be entitled to the benefits in the event of death of the Insured.** **PLEASE BE ADVISED THAT MINORS STATED AS BENEFICIARIES (WITHOUT THE APPOINTMENT OF A TRUSTEE) WILL ONLY RECEIVE PAYMENT UPON ATTAINING AGE 18.**		
Name:	D.O.B.:	
Relationship:	Telephone Number:	% Designation:
Trustee (if beneficiary is a minor)	**D.O.B of Trustee**	**Tel# of Trustee**
Name:	D.O.B:	
Relationship:	Telephone Number:	% Designation:
Trustee (if beneficiary is a minor)	**D.O.B of Trustee**	**Tel# of Trustee**
Name:	D.O.B:	
Relationship:	Telephone Number:	% Designation:
Trustee (if beneficiary is a minor)	**D.O.B of Trustee**	**Tel# of Trustee**
Name:	D.O.B:	
Relationship:	Telephone Number:	% Designation:
Trustee (if beneficiary is a minor)	**D.O.B of Trustee**	**Tel# of Trustee**
Name:	D.O.B:	
Relationship:	Telephone Number:	% Designation:
Trustee (if beneficiary is a minor)	**D.O.B of Trustee**	**Tel# of Trustee**
Name:	D.O.B:	
Relationship:	Telephone Number:	% Designation:
Trustee (if beneficiary is a minor)	**D.O.B of Trustee**	**Tel# of Trustee**

INSURANCE/INVESTMENT OPTIONS		LAST MINUTE EXPENSE PLANS	
Basic Plan	$	**TIP Family Protector**	$
Super Club	$	**Additional Death Benefit**	$
TIP Kids Benefit	$		
TIP for Life Options	$		
Spouse's Insurance	$		
INVESTMENT OPTIONS		**LOAN REPAYMENTS**	
TIP Accumulator Club	$	**Regular Loan**	$
TIP Pool Fund	$	**Educational Loan**	$
TIP Grad	$	**TIP Express Loan**	$
TIP Educator	$	**TIP Debt Consolidation Loan**	$
TIP Partner Club	$	**TIP Auto Loan**	$
TIP For Wealth	$	**TIP Vacation Loan**	$
TIP Money Multiplier Protector	$	**Other Loan**	$
		Compulsory Savings	$
		TOTAL MONTHLY DEDUCTIONS	$

COMMENTS:

MEDICAL & GENERAL QUESTIONS
IF YOU, YOUR SPOUSE, DEPENDENTS AND FAMILY MEMBERS ARE INSURED, PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Have you or any of the proposed persons to the best of your knowledge and belief, ever been treated or told they had diabetes, abnormal blood pressure, any disorder or disease of the heart, lung, back or spine, mental or nervous condition, cancer, leukaemia, poliomyelitis, emphysema, muscular dystrophy, multiple sclerosis, or cirrhosis of the liver, or any other disease, disorder, defect or injury?
   Yes □ No □ If yes, give details including physicians and dates.
   ____
   ____
2. AIDS (Acquired Immune Deficiency Syndrome) Have you or any of the proposed persons received medical advice, or treatment, in connection with AIDS or an AIDS related condition or a sexually transmitted disease? Have you or any of the proposed persons been told you had AIDS or AIDS related complex? Have you or any of the proposed persons had or been told you had a positive blood test or antibodies to the AIDS virus? (Human Immune Deficiency Virus)?
   Yes □ No □ If yes, please explain including physicians and dates.
   ____
   ____
3. Do you or any of the proposed persons have any of the following which are unexplained: Fatigue, weight loss, diarrhoea, enlarged lymph nodes or unusual skin lesions? Yes □ No □ If yes, please explain including physicians and dates.
   ____
   ____
4. Have you or any of the proposed persons ever made application for accident, sickness, disability, hospital, or life insurance which has been declined, postponed or withdrawn or has any policy or certificate of such insurance issued to them been modified, rated up, cancelled or renewal refused? Yes □ No □ If yes, please explain including physicians and dates.
   ____
   ____
5. Are you or any of the proposed persons aware of any other medical condition not mentioned above? If yes, please explain. Yes □ No □
   ____
   ____
6. To the best of your knowledge, are you or any of the proposed persons in good health? Yes □ No □ If no, please explain including physicians and dates.
   ____
   ____
7. Does any of the insured or proposed resides overseas? Yes □ No □ If yes, please state who, where and their occupations.
   ____
   ____

ALL STATEMENTS IN THIS APPLICATION ARE TRUE AND COMPLETE AND TO THE BEST OF MY KNOWLEDGE AND BELIEF. I CERTIFY THE GOOD HEALTH OF MYSELF AND THE PROPOSED DEPENDENTS. FALSE OR MISLEADING INFORMATION/ANSWERS MAY LEAD TO THE CANCELLATION OF THIS APPLICATION OR POLICIES.

Applicant's Signature ______________________ Date ______________________

Representative's Name (Please Print) ______________________ Representative's Signature______________________

✂..

TIP FRIENDLY SOCIETY SALARY DEDUCTION AUTHORISATION	
Name:	Teacher's No:
School Name:	School Code:

I hereby apply for membership in TIP Friendly Society, and agree to participate in the Teachers' Income Protector Programme operated by the Society according to the terms and conditions outlined in the Brochure. I do agree to conform to the rules and amendments of the Society. I am aware that this programme is not in effect until the stated premium is received and a contract (containing the terms and conditions) is issued to the member. Please deduct from my salary the sum of $______________ monthly as of ______________ and make payment to TIP Friendly Society, 80 Half Way Tree Road, KINGSTON 10. Tel: 920-8399, 960-0729, 968-5623. ***This order must not be cancelled except on the authority of TIP Friendly Society.***

Signature of applicant:	Date: