TIP Friendly Society

Application Form

TIPFS – MSD – 01 - 2022

Please fill out application form completely and accurately in BLOCKED CAPITAL LETTERS. Write not applicable (N/A) in areas that do not apply. Coverage terminates at retirement or age seventy (70), whichever comes first and Group Life coverage is reduced by 50% at the age of 65. Minors (under the age of 18) listed as beneficiaries, must be appointed a trustee. This application will be effected the day that the first or change of premium is received by TIP Friendly Society.
Conditions Apply

☐ New ☐Policy Change ☐Reallocation ☐Reactivation ☐Name Change ☐Removal/Addition

Section A: Personal Information
Documented Evidence (Deed Poll or Marriage Certificate) must be Submitted for Name Change.

Date:	Member No.:	TRN:
☐Miss ☐Ms. ☐Mrs. ☐Mr.		
First Name	Middle Name	Last Name / Maiden Name
Gender: ☐ Male ☐ Female	Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Common Law	
Date of Birth (D.O.B): DD MM YYYY	Email:	
Current Address:		
Mailing Address:		
Telephone Numbers: (Home)	(Mobile 1)	(Mobile 2)

Section B: Employment Information

Institution Code:	Place of Work:	
Occupation:	Annual Salary:	Length of Employment:
Employment Status: ☐Permanent Full-Time ☐Temporary Full-Time ☐Part-Time ☐Other(State below)		
Work Address:		
Telephone Numbers:	Fax Number:	Email:

Section C: Spouse's Information (ONLY IF INCLUDED FOR COVERAGE)

☐Miss ☐Ms. ☐Mrs. ☐Mr.		
First Name	Middle Name	Last Name / Maiden Name
Gender: ☐ Male ☐ Female	Marital Status: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed ☐Common Law	
Date of Birth (D.O.B): DD MM YYYY	TRN:	Email:
Current Address:		
Telephone Numbers: (Home)	(Mobile 1)	(Mobile 2)
Place of Work:		
Occupation:	Annual Salary:	Length of Employment:
Employment Status: ☐Permanent Full-Time ☐Temporary Full-Time ☐Part-Time ☐Self-Employed ☐Unemployed ☐Retired ☐Other(State)		
Work Address:		
Telephone Numbers:	Fax Number:	Email:

Section D: Children (ONLY IF INCLUDED FOR COVERAGE)
Sign-up required before Age 18; Coverage up to Age 30

Name:		
D.O.B.	Relationship:	Current School:
Name:		
D.O.B.	Relationship:	Current School:
Name:		
D.O.B.	Relationship:	Current School:
Name:		
D.O.B.	Relationship:	Current School:
Name:		
D.O.B.	Relationship:	Current School:
Name:		
D.O.B.	Relationship:	Current School:

Section E: Beneficiaries

Please state beneficiaries who will be entitled to the benefits in the event of death of the Insured. PLEASE BE ADVISED THAT MINORS (UNDER THE AGE OF 18) STATED AS BENEFICIARIES, MUST BE APPOINTED A TRUSTEE. THIS TRUSTEE APPOINTMENT WILL REMAIN IN EFFECT UNTIL THE MINOR ATTAINS AGE 18.

Name:	D.O.B:	
Relationship:	Telephone Number:	% Designation:
Trustee (if beneficiary is a minor)	**D.O.B of Trustee :**	
Relationship of Trustee to Minor	**Telephone Number of Trustee:**	
Name:	D.O.B:	
Relationship:	Telephone Number:	% Designation:
Trustee (if beneficiary is a minor)	**D.O.B of Trustee :**	
Relationship of Trustee to Minor	**Telephone Number of Trustee:**	
Name:	D.O.B:	
Relationship:	Telephone Number:	% Designation:
Trustee (if beneficiary is a minor)	**D.O.B of Trustee :**	
Relationship of Trustee to Minor	**Telephone Number of Trustee:**	
Name:	D.O.B:	
Relationship:	Telephone Number:	% Designation:
Trustee (if beneficiary is a minor)	**D.O.B of Trustee :**	
Relationship of Trustee to Minor	**Telephone Number of Trustee:**	
Name:	D.O.B:	
Relationship:	Telephone Number:	% Designation:
Trustee (if beneficiary is a minor)	**D.O.B of Trustee :**	
Relationship of Trustee to Minor	**Telephone Number of Trustee:**	
Name:	D.O.B:	
Relationship:	Telephone Number:	% Designation:
Trustee (if beneficiary is a minor)	**D.O.B of Trustee :**	
Relationship of Trustee to Minor	**Telephone Number of Trustee:**	

Section F: General Information

How did you hear about TIP?

☐ TIP Rep. ☐TIP Member ☐School ☐Friend ☐Relative ☐Facebook ☐Website
☐Twitter ☐Other

Your preferred local media are:

☐ Radio, state ____________________
☐ Television, state ____________________
☐ Print Media, state ____________________
☐ SOCIAL MEDIA - ☐Facebook ☐Twitter ☐Instagram ☐Other____________

Please choose your preferred method of certificate delivery (tick one):

☐Email ☐Mail to home address ☐Mail to work address ☐Hand delivery ☐Other (Please state)____________

Section G: Comments

Section H: Medical & General Questions (Only for the Insured)

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 name(s) and dates seen.

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 name(s) and dates seen.

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 name(s) and dates seen.

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 name(s) and dates seen.

5. Are you or any of the proposed persons aware of any other medical condition not mentioned above?

   ☐ Yes ☐ No If yes, please explain.

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 name(s) and dates seen.

7. Does any of the insured or proposed reside overseas?

   ☐ Yes ☐ No If yes, please state who, where and their occupations.

Section I: Premium Payments Allocation Authorization

IMPORTANT: Please indicate here how the monthly salary deduction should be allocated

Insurance Products (Personal Accident & Group Life)			**Saving Products**	
TIP Basic Plan		$	TIP Accumulator	$
TIP Gold Club	Option:		TIP Pool Fund	$
TIP SuperClubs		$	TIP Grad Club	$
TIP for Life	Option:	$	TIP Educator	$
TIP Kids Benefit	Option: x	$	TIP Money Multiplier Protector	$
Spouse's Insurance		$	TIP Partner Club Option:	$
Insurance Products Total		**$**	TIP Compulsory Savings	$
			TIP for Wealth	$
			TIP Christmas Club	$
			Other	$
			Other	$
			Other	$
			Other	$
			Other	$
			Other	$
			Saving Products Total	**$**

Loans Repayments			
TIP Regular Loan	**$**	TIP Auto Loan	$
TIP Education Loan	**$**	TIP Debt Consolidation Loan	$
TIP Express Loan	**$**	TIP Vacation Loan	$
TIP Partner Club Loan	**$**	Other Loan	$
		Loan Repayments Total	**$**
TOTAL MONTHLY DEDUCTION	**$**		

Section J: Disclaimer & Signature (Please tick the box that is applicable)

☐ I hereby apply for membership in **TIP Friendly Society**, and agree to participate in the Income Protector/Savings/Loans Programme operated by the Society according to the terms and conditions that have been outlined. I declare that all statements/answers in this application are true and complete to the best of my knowledge and belief. I affirm the good health of myself and proposed dependents. I understand that false or misleading information/answers will lead to the cancellation of this application and/or policy.

☐ I do agree to abide by the Policies, Rules and Regulations governing the Society and itsmodus operandi and will conform to the Rules and Amendments of the Society. *As a new member, I am aware that the amount of $2,000 for the purchase of permanent shares will be satisfied first before any of the membership benefits are applicable to me.* I am aware that this programme is not in effect until the stated premium is received.

☐ I declare that all statements/answers in this application are true and complete to the best of my knowledge and belief. I affirm the good health of myself and proposed dependents. I understand that false or misleading information/answers will lead to the cancellation of this application and/or policy. I do agree to abide by the Policies, Rules and Regulations governing the Society and its modus operandi and will conform to the Rules and Amendments of the Society.

Applicant's Signature:______________________ Date:______________________

Representative's Name (Please Print):______________________ Representative's Signature:______________________

TIP Friendly Society

TIP Friendly Society
80 Half-Way-Tree Road
Kingston 10
Phone: (876) 929-1710

SALARY DEDUCTION AUTHORIZATION FORM

MEMBER NUMBER: ______________________ TOTAL MONTHLY DEDUCTION $ ______________________

Name: ____

Institution Code: ______________________ Place of Work: ______________________

I hereby authorize the above employer to deduct the total monthly deduction amount as indicated from my salary each month and remit to **TIP Friendly Society** as of ______________________. This order must not be cancelled or changed except on the authority of TIP Friendly Society.

Applicant's Signature: ______________________ Date: ______________________

TIP Representative: ______________________ Date: ______________________