Life Assurance Benefit Application Form

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ First Name Middle Name Last Name

Address

Telephone No. (H) (W) Date of Birth D M Y

Employer Occupation

Beneficiary

Address

Premium Payment Mode Automatic Deduction

Effective Date Account Number

Applicant's Signature Date Witness Date

Checked by Date Approved by Date

By signing below, you affirm that the information you have given in this application is true and complete and forms part of this application and that you have not withheld any information. In addition, you agree to conform to the By-Laws and any amendments thereto of the St. Kitts Co-operative Credit Union Life Assurance Benefit.