TIP Friendly Society
Loan Upgrading & Reallocation Form

This application form exists solely for members who have accessed our loan(s) facility to make the necessary adjustments to their savings 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 and is reduced by 50% at the age of 65. Minors listed as beneficiaries will only receive proceeds upon reaching the age of majority (18). This application will be effected the day that the first or change of premium is received by TIP Friendly Society. *Conditions Apply*

☐Reduce Payment ☐Payment Change (SAVINGS ONLY) ☐Loan Increase ☐Loan Decrease ☐Reallocation

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

School 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: Type of Loan

☐Regular ☐Education ☐Partner ☐Auto ☐Debt Consolidation ☐Express ☐Vacation

EFFECTIVE DATE:

Section D: Premium/Loan Repayment

Insurance Products (Personal Accident & Group Life)			**Saving Products**		
TIP Basic Plan		$	TIP Accumulator		$
TIP SuperClubs		$	TIP Pool Fund		$
TIP for Life	Option:	$	TIP Grad Club		$
TIP Kids Benefit	Option: x	$	TIP Educator		$
Spouse's Insurance		$	TIP Partner Club	Option:	$
Insurance Products Total		**$**	TIP Money Multiplier Protector		$
Last Minute Expense Plans& Home & Content Insurance			TIP Compulsory Savings		$
	Option		TIP for Wealth		$
TIP Family Protector		$	TIP Christmas Club		$
TIP Family Protector Plus		$	Other		$
Additional Death Benefit		$	Other		$
TIP Home Insurance		$	Other		$
TIP Content Insurance		$	Other		$
Other		$	Other		$
Last Minute Expense Plans Total		**$**	**Saving Products Total**		**$**

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 E: Disclaimer & Signature

I declare that all statements/answers in this application are true and complete to the best of my knowledge and belief. I af firm the good health of myself and proposed dependents. I understand that: beneficiaries named on previous application remains as is; and, 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_____

SALARY DEDUCTION AUTHORISATION FORM

MEMBER NUMBER _____ TOTAL MONTHLY DEDUCTION $_____

Name : _____

Employer Number: _____ 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:** _____

Form last updated October 2020

Section I: 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.

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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.

Applicant's Signature _____ **Date:** _____

TIP Representative: _____ **Date:** _____