



Application Form

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
- MOEYI PAID (Teacher) MOEYI PAID (Special) BURSAR PAID OTHER

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

Date:		Member No.:		TRN:	
<input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Mr.					
First Name		Middle Name		Last Name	
Maiden Name					
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Common Law			
Date of Birth (D.O.B): DD MM YYYY		Email:			
Current Address:					
Mailing Address (if different from above):					
Telephone Numbers: (Home)		(Mobile 1)		(Mobile 2)	
Social Media Handles: Facebook:		Instagram:		Twitter:	

Section B: Employment Information

Institution Code:		Place of Work:			
Occupation:		Annual Salary:		Length of Employment:	
Employment Status: <input type="checkbox"/> Permanent Full-Time <input type="checkbox"/> Temporary Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Other(State below)					
Work Address:					
Telephone Numbers:		Fax Number:		Email:	

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

<input type="checkbox"/> Miss <input type="checkbox"/> Ms. <input type="checkbox"/> Mrs. <input type="checkbox"/> Mr.					
First Name		Middle Name		Last Name	
Maiden Name					
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> 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: <input type="checkbox"/> Permanent Full-Time <input type="checkbox"/> Temporary Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Self-Employed <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> 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:

Section E: Family Protector (ONLY IF INCLUDED FOR COVERAGE)

Maximum of 6 persons (including the applicant, spouse, children & any combination of up to 2 persons of member's parents or parents-in-law).

Sign-up required before age 55 for TIP Member, below age 75 for spouse, parents and parents-in law, and before age 18 for children.

No Member shall receive more than 2 adult dependent death benefits..

Member's Name:

Name:

D.O.B.:

Relationship:

Name:

D.O.B.:

Relationship:

Name:

D.O.B.:

Relationship:

Name:

D.O.B.:

Relationship:

Name:

D.O.B.:

Relationship:

Section F: 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 G: General Information

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 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: Comments

Section J: 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 Super Clubs	\$	TIP Pool Fund	\$
TIP for Life	Option:	TIP Grad Club	\$
TIP Kids Benefit	Option: X	TIP Educator	\$
Spouse's Insurance	\$	TIP Partner Club	Option: \$
TIP Family Protector	Option 1:	TIP Compulsory Savings	\$
	Option 2:	TIP for Wealth	\$
	Option 3:	Other	\$
Insurance Products Total	\$	Other	\$
Comments:		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 K: 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 its modus 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 authorize TIP Friendly Society to deduct my monthly premium/loan payment from my account if my employer fails to remit same.
- 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
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: _____



DATA PRIVACY CONSENT FORM

- The Data Act (“the Act”) was passed in June 2020 in Jamaica and is scheduled to come into effect on December 1, 2023. This stipulates that we must seek and obtain your consent prior to processing data collected from you.
- For TIP (Data Controller) to provide insurance, savings, and loan services to you, we require that you provide us with identifiable information about yourself (personal data) and the services you require.
- Listed below are various consents we require from you. We ask that you read them carefully and if you agree, please tick the appropriate boxes, sign in the space provided and return it to us. If you do not provide us with your written consent, by law, we will be unable to conduct business with you.

Please note that we will treat your data in the strictest confidence and as prescribed by law.

PERSONAL DATA PROTECTION

Mandatory Consents

- I confirm that I have read and understood the Data Protection Privacy Notice provided to me and that I am duly authorized to sign this form.

Consent to collect Sensitive Data

- I consent to the collection and processing of Sensitive Data.

Consent to share Data.

- I consent to the sharing/seeking of information from insurers, financial companies, databases and/or other duly authorized bodies to verify the answers provided by me.

Consent to conduct Business.

- I consent to conduct business with **TIP Friendly Society** online and electronically including, but not limited to requesting and receiving updates, sending, and receiving all documents, communications, notices, and all other correspondences electronically.

- I further consent that any document delivered to TIP may be electronically signed. Electronic signatures of the parties are intended to have the same force and effect as manual signatures.

DATA PROTECTION PRIVACY

Personal Data Use

We may collect the following personal data from you and other third parties:

- Your data: We use personal data and sensitive personal data such as medical details (Sensitive Data).
- Claims/health data: If a claim is made, we may also collect personal information about the claim/health from you and any relevant third parties.
- Credit data, we may need data on your credit status.

Sharing of your Personal Data

We may share your data (where appropriate/applicable) as follows:

- We may also share personal data with third parties if you engage with us through a third party, for example through financial organizations or, in the case of another insurance organization.
- With reinsurers who provide reinsurance service to **TIP Friendly Society**
- With any intermediary or third party acting for you.

How long do we hold your personal data?

We retain personal data to satisfy our legal obligations.

Data subject rights

You have the following rights in relation to your data which is held by us:

- | | |
|---|---|
| <ul style="list-style-type: none">• To ask for details of your data held by us.• To ask for a copy of your Data.• To have any inaccurate or misleading Data rectified.• To have your Data erased | <ul style="list-style-type: none">• To object to the processing of your data.• To transfer your data to a third party.• Where processing is based on consent, the right to withdraw such consent. |
|---|---|

TIP Friendly Society Privacy Policy

Please note that this Data Protection Notice is not a standalone section and should be reviewed in conjunction with our Privacy Policy which is available online <https://tipfriendly.com> or a copy will be provided to you upon request.

Data Protection Contact Details

If you have any questions about your Data, you can contact us at mktgsales@tipfriendly.com or 876-618-1914.

Applicant's Name _____

Applicant's Signature _____

Date _____
MM/DD/YY

Representative's Name _____

Representative's Signature _____

Date _____
MM/DD/YY



TIP Friendly Society

TIP Friendly Society

Authority & Indemnity

For Electronic Mail, Internet, Verbal and/or All Other Third Party Instructions

THIS DEED OF AUTHORITY AND INDEMNITY is made the _____ day of _____

20 _____, **BETWEEN** _____ in the parish of _____

(hereinafter called "the Member"), and **TIP Friendly Society**, with registered office situated at "80 Half Way Tree Road, Kingston 10, in the parish of Saint Andrew, (hereinafter called "**the Society**").

WHEREAS:

The Member has requested that **the Society** honour his/her instructions sent by means of electronic mail, internet, verbal and/or other third party instructions to **the Society** from time to time in relation to any and all of the Member's existing accounts, facilities and other arrangements with **the Society** and any accounts, facilities and other arrangements which the Member may now or in the future have with **the Society** (instructions sent by such transmissions being hereinafter referred to as "electronic mail, internet, verbal and/or third party instructions").

IN CONSIDERATION of **the Society** agreeing to accept electronic mail, internet, verbal and/or third party instructions from the Member as aforesaid, the Member agrees:

1. that **the Society** may act on any electronic mail, internet, verbal and/or third party instructions given by the Member from time to time, without requiring confirmation bearing actual signatures in the cases of electronic mail, internet, verbal and/or third party instructions, and the Member voluntarily and with full knowledge takes and assumes any and all risks, associated therewith;
2. that it is understood at all times that the ability of **the Society** to act on electronic mail, internet, verbal and/or third party instructions depends upon the normal functioning of the various electronic communication equipment utilised by **the Society** which may involve third party support equipment. **The Society** shall be under no obligation to maintain any facility or equipment for the receipt of electronic instructions and the member shall not hold **the Society** liable for any loss consequent on the non-availability of such facility or equipment;
3. that it is understood that **the Society** will not be held responsible any delay in acting on instructions or any consequences thereof;
4. that once electronic mail, internet, verbal and/or third party instructions have been sent to **the Society** purportedly by the Member (or by any of the Members, if more than one) authorised from time to time to sign in accordance with the mandate or other valid instructions from the Member to **the Society**, **the Society** shall have no obligation to check or verify the authenticity or accuracy of such electronic mail, internet, verbal and/or third party instructions purporting to have been sent by the Member (regardless of whether **the Society** may have, or may in the future, choose to so check or verify) and may act thereon as if same had been duly given by the Member.
5. that in acting on electronic mail, internet, verbal and/or third party instructions **the Society** shall be deemed to have acted properly and to have fully performed all obligations owed to the Member, notwithstanding that such electronic mail, internet, verbal and/or third party instructions may have been initiated, sent or otherwise communicated in error or fraudulently, and the Member shall be bound by such electronic mail, internet, verbal and/or third party instructions on which **the Society** may act if **the Society** has in good faith acted in the belief that such electronic mail, internet, verbal and/or third party instructions were given by the Member;
6. that the Member shall not provide **the Society** with written instructions bearing original signature(s) where prior instructions to effect the same transaction have been sent to **the Society** by electronic mail, internet, verbal and/or third party instructions. The member acknowledges that where electronic mail, internet, verbal and/or third party instructions are followed by subsequent written instructions

bearing original signature(s) contrary to the above, this may lead to **the Society** giving effect to these instructions more than once.

The Member acknowledges that in such event he/she shall bear the risk of such duplication occurring and shall indemnify and hold **the Society** harmless against all losses, liabilities, claims or damages which may arise as a result of **the Society** acting more than once on such duplicated instructions;

7. that **the Society** may, in its absolute discretion, decline to act on or in accordance with the whole or any part of electronic mail, internet, verbal and/or third party instructions pending further enquiry to or further confirmation (whether written or otherwise) by the Member, so however that **the Society** shall not be under any obligation to so decline in any case, and **the Society** shall in no event or circumstances be liable in any respect for not so declining;
8. to release **the Society** from and indemnify **the Society**, its employees and agents harmless upon demand from and against all claims, liabilities, losses, damages, costs, charges, counsels fees and expenses howsoever arising in consequence of, or in any way related to, **the Society** having acted in accordance with the whole or any part of any electronic mail, internet, verbal and/or third party instructions or having exercised (or failed to exercise) the discretion conferred upon **the Society** in Clause 5 above; and
9. that irrespective of the place of origin of the electronic mail, internet, verbal and/or third party instructions the indemnity given above covers all existing and future accounts of the member and shall be governed by and construed in accordance with the laws of Jamaica.

Dated this day of 20

EXECUTED AS A DEED BY:

Member's Name

Member's TRN Number

Maiden Name *(if applicable)*

Member's TIP Account Number

Email Address

Contact Number

Member's Signature _____

In the presence of

Print Name of Witness – JP / Notary Public

Signature of Witness – JP / Notary Public

FOR THE SOCIETY USE ONLY
Authenticated by

Authorized Signatory & Date