The Family Indemnity Plan

CHANGE OF PLAN

This Change of Plan shall be effective on the first day of the month following the date the Insured delivers this form to and is received by your Organization.

Insured Name _____Certificate Number _____

Address of Insured_____

E-mail _____

Organization _____

Current Date _____

Current Plan A_____ B_____ C _____ D _____ E _____

I wish to change to Plan B _____ C _____ D _____ E _____ F _____

Effective Date of Change _____

I understand that there will be a six-month waiting period for the higher benefit under this change of plan. I also understand that if a claim is incurred during the six month waiting period, the claim benefit will be based on the original plan (except in the case of accidental death). I further understand that starting with the Effective Date of Change, the premium I will pay will be greater due to the increase in coverage under the new plan.

Signature of Insured_____ Date_____

Signature of Authorized Organization Officer _____

R-01/2014

CUNA MUTUAL GROUP

CMFG Life Insurance Company

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PRINT NAME OF STAFF SUBMITTING PLAN CHANGE