



ENROLLMENT FORM		
APPLICANT NAME:		
DOB*:		Cell Phone:
Current Address:		
City:	State:	Zip Code:
Email:		

DEPENDENTS		
SPOUSE		
Name:	DOB*:	
Address (if different from above):		
City:	State:	Zip Code:
Cell phone:	Email:	

CHILDREN		
CHILDREN	Date of Birth* (mm/dd/yyyy)	Address/Residence

PARENTS (Biological)		
Name	Date of Birth* (mm/dd/yyyy)	Residence Address

BIOLOGICAL SIBLINGS INFORMATION		
Name	Date of Birth* (mm/dd/yyyy)	Residence

MEMBERSHIP ENROLLMENT		FOR OFFICIAL USE ONLY
Are you an Immigrant?	Enrollment fee \$400 and a monthly subscription of at least \$45	APPROVED
YES NO	Date paid:	YES NO
	Method of payment	
IF MORE SPACE IS NEEDED FOR CHILDREN AND/OR SIBLINGS, PLEASE ATTACH ANOTHER PAGE.		
Note: Initial benefits effective 120 days after approved enrollment and payment of Enrollment fee		

For faster service, download, print, and fill in all the required information, scan and email your application to:
Ukarimuusa@gmail.com or info@ukarimuusa.com

OR

Send via USPS Mail:

**Ukarimu
 PO Box 1471
 Fontana, CA 92334**

*Dates of Birth MUST be included for this application to be approved

Be sure to read the contents on the second page before signing.

WAIVERS/ WAIVER OF LIABILITY/ HOLD HARMLESS AGREEMENT

1. In consideration of my voluntary membership and enrollment into Ukarimu, I hereby agree and consent that my continued membership is subject to my continued residence in the United States of America. Should my residence change, I consent that my membership shall only continue if I continue meeting the obligations of my membership.
2. I further hereby agree and consent that my continued membership is subject to my performance and compliance. Should my membership be revoked for reasons of non-performance and non-compliance, I consent that there will be no refunds of any kind. If I terminate my membership, there shall be no refunds of any kind.
3. I further hereby agree pay my dues as they become due. This amount may vary depending on the number of dependents I have. If the payment is not received by the deadline date, then your membership may be terminated. Once your membership is terminated, you will have an opportunity to rejoin the organization after one open enrollment cycle and a four month (120 days) waiting period thereafter.
4. I understand that my continued membership is subject to my performance and compliance per all guidelines. Should my membership be revoked by the fund administrators for reasons of non-performance and/or non-compliance, I consent that there shall be no refunds of any kind. If I terminate my membership, there shall be no refunds of any kind.
5. If I withdraw voluntarily, then I will only be eligible to rejoin Ukarimu after at least one year.
6. I understand that the membership/enrollment fee is non-transferable and/or non- refundable.
7. I understand that bereavement benefits shall not be paid out until a Claim form is filled and submitted to Ukarimu. I further agree to provide proof of my relationship to a dependent that has died. The proof being defined as: official death certificate (due to urgency, notarized, scanned and e-mailed copies may be okay), and an affidavit declaring the truth of the loss of relatives outside USA. I will sign a document confirming receipt of bereavement check. For a death that occurs outside the USA, these documents shall be provided within 90 days from the date of death.
8. I confirm that all the names and dates of birth I have provided for my dependents are true to the best of my knowledge. Any dependent that has no date of birth provided shall not be covered.
9. I understand that dependents shall be limited to legally married spouse, Children, Siblings by birth, and Parents by blood. Legally adopted children with proper documentation shall be covered.
- 10. I understand and agree that step parents, step brothers, and step sisters shall not be covered by this program.**
11. I understand that I may add qualifying dependents through birth of a child and/or marriage within 30 days of such occurrence.
12. I further hereby agree and consent that the company at its discretion shall verify any reported death. I agree to submit all requested documents that may be required before and/or after the funds are disbursed depending on the request.
13. In the event a dead person is claimed by myself and any of my brothers or sisters who are members of Ukarimu, Ukarimu shall issue only one payment (benefit amount) to cover that one death (one event). The members who jointly have that claim shall advise the Executive Board to whom among them shall receive the benefit. Otherwise such benefit shall be split equally amongst such members. For example, if you and your brother are members and have each of you covered your mother, then Ukarimu shall either make one payment of \$8,000 which may be payable through issuance of one check after consultation with both of you or the check may be split into two (\$4,000 each) payable to both of you.
14. Notwithstanding all terms and provisions, I further hereby consent that nothing shall be paid to me during the administrative period of said fund. Accordingly, unless otherwise stated the benefits shall accrue not earlier than 120 days from the end of the enrollment month (period) or from the date the application was submitted, whichever comes later.
15. It is my express intent that this Release and Hold Harmless Agreement shall bind my spouse and members of my family if I am alive, and my heirs, assigns and personal representative if I am deceased.
16. I further hereby confirm that I have read and understood these stipulations and undertake to abide with such as written.

IN SIGNING THIS WAIVER/RELEASE, I ACKNOWLEDGE AND REPRESENT THAT I have read the foregoing, understand it and sign it voluntarily as my own free act and deed; no oral representations, statements, or inducements, apart from the foregoing written agreement, have been made; I am at least eighteen (18) years of age and fully competent; and I have voluntarily executed the Release For full, adequate, and complete consideration fully intending to be bound by the same.

Name:	Signature:
Date:	County: State: