Health Insurance Department
Application for a Certificate of Entitlement
(for persons 65 years of age or older)

FOR OFFICAL USE

Certificate Number: ________________

ID Form Attached: ☐

Verified by: ______________________

Applicant Details (Please Print)

Name: [ ] **(Mr./Mrs./Miss/Ms.)** [ ] **(First Name)**

[ ] **(Middle Name)** [ ] **(Last Name)**

Mailing Address: [ ]

Parish: [ ] Postal Code: [ ]

Telephone Number: [ ] -- [ ] Nationality: ______________________________

Eligibility Details

Date of Birth (dd/mm/yy): [ ] / [ ] / [ ] Age on Last Birthday: [ ]

Present Employer (if any): ____

Please answer ALL questions as they apply to you: **Circle One**

CSR Verification Only:

Eligibility verified: *(check if correct)*

	Question	Circle One		CSR
(1)	Do you possess Bermudian status? (Please attach a photocopy of passport with Bermudian status stamp or DOI letter)	Yes	No	[ ]
(2)	Are you residing in Bermuda at present?	Yes	No	[ ]
(3)	Have you resided in Bermuda for ten (10) continuous years during the last twenty (20) years immediately preceding this application?	Yes	No	[ ]
(4)	During those ten (10) years have you been absent abroad for more than three (3) months in any year (other than for purposes of educational/vocational training or on holiday)?	Yes	No	[ ]

If yes, please give dates and reasons for each such absence.

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Notes:

During those ten (10) years have you been insured for standard hospital benefits for at least five (5) years? Yes No [ ]

I declare that the information above is accurate to the best of my knowledge.

Signed: ____ Date (dd/mm/yy): [ ] / [ ] / [ ]

MANAGER SPOT CHECK ONLY

Date Reviewed (dd/mm/yy): [ ] / [ ] / [ ] Signature:______________________________

Notes:____

When completed, this Form should be returned to the Health Insurance Department.
Mailing Address: Health Insurance Department, P.O. Box HM 2160, Hamilton HM JX
Street Address: Sofia House, 2nd Floor, 48 Church Street, Hamilton HM 12