# 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: _____

Email Address: _____

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Eligibility Details

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

Present Employer (if any): _____

**CSR Verification Only:**

***Eligibility verified:*** *(check if correct)*

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

(1) Do you possess Bermudian status? [ ]
(Please attach a photocopy of passport with Bermudian status stamp or DOI letter)

(2) Are you residing in Bermuda at present? [ ]

(3) Have you resided in Bermuda for ten (10) continuous years during the last twenty (20) years immediately preceding this application? [ ]

(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)? [ ]

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

Notes:

_____

_____

During those ten (10) years have you been insured for standard hospital benefits for at least five (5) years? [ ]

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

Signed: _____ Date (dd/mm/yy): / /

**MANAGER 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