Health Insurance Department
Voluntary
Application for Enrolment

Plan Type: ☐ **FutureCare** ☐ **HIP**

☐ New Customer ☐ Re-Enrolment*

FOR OFFICIAL USE

Policy Number: _____

Effective Date (d/m/y): _____

Existing AR Number if Re-Enrolment:

_____

Approved By and Date (d/m/y): _____

Applicant Details (Please Print)

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

(Middle Name) **(Last Name)**

Mailing Address:

Parish: Postal Code:

Date of Birth (dd/mm/yy): / / Telephone Number: -

Email Address: _____

Social Insurance Number: Certificate of Entitlement Number (if applicable): _____

Are you a resident of Bermuda? ☐ Yes ☐ No Are you currently employed? ☐ Yes ☐ No

*If Re-Enrolment, should there be a lapse in coverage? ☐ Yes ☐ No

If yes, list lapse Start and End Dates: _____

Medical Declaration

Have you had Health Insurance before? ☐ Yes ☐ No Previous Insurer: _____

Date Expired (dd/mm/yy): / /

Have you had HIP or FutureCare Insurance before? ☐ Yes ☐ No

Are you currently scheduled for medical treatment(s) within the next 30 days? ☐ Yes ☐ No

If yes, Type of Treatment: _____

Date of Treatment (dd/mm/yy): / / Doctor's Name: _____

***Please Note:** We do not cover any non-emergency treatment(s) received within 30 days of the submission of this application. Maternity benefits are not covered for 10 months from the effective date of the policy.

I declare that the information above is accurate to the best of my knowledge. I agree to authorize the Health Insurance Department to consult with the hospitals and doctors facilities regarding any pending treatments.

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

Premium Payment: The first premium is to be paid on enrolment. Cheques should be made payable to the Health Insurance Fund or the FutureCare Fund. This application is subject to approval, and any premium paid will be held pending such approval.

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