Health Insurance Department:

Health Insurance and FutureCare Plan Guide

Ministry of Health
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
Phone: 441-295-9210 Fax: 441-295-9213 Website: www.gov.bm Email: hip@gov.bm
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Health Insurance Department Health Plans

As per the Health Insurance Act 1970 (Act), the Health Insurance Department (HID) manages the Health Insurance Plan (HIP and HIP Youth) and FutureCare policies. Table 1, below, shows the benefits that are offered under each policy type:

**Table 1: HID Basic Benefits:**

<table>
<thead>
<tr>
<th></th>
<th>HIP</th>
<th>FutureCare Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Local In-Patient</strong></td>
<td>All costs associated with overnight stay. E.g. room and board, nursing</td>
<td>All costs associated with overnight stay. E.g. room and board, nursing</td>
</tr>
<tr>
<td></td>
<td>• KEMH - Covered at 100%</td>
<td>• KEMH - Covered at 100%</td>
</tr>
<tr>
<td></td>
<td>• MAWI – Covered at 100% up to 40 days in-patient stay</td>
<td>• MAWI – Covered at 100% up to 40 days in-patient stay</td>
</tr>
<tr>
<td></td>
<td>• New born delivery – covered at 100%</td>
<td>During hospitalization (Maximums per admission)</td>
</tr>
<tr>
<td><strong>Profession Physicians Fees</strong></td>
<td>During hospitalization (Maximums per admission)</td>
<td>• Surgery - $2,114</td>
</tr>
<tr>
<td></td>
<td>• HIP fees based on Bermuda Hospitals Board (Medical and Dental Charges) Order 2015</td>
<td>• Anesthetist - $1,171</td>
</tr>
<tr>
<td></td>
<td>• Health Insurance (FutureCare Plan) (Additional Benefits) Order 2009 &amp; Health Insurance (Health Insurance Plan) (Additional Benefits) Order 1988</td>
<td>• Internal Medicine - $1,643</td>
</tr>
<tr>
<td></td>
<td>• Health Insurance (FutureCare Plan) (Additional Benefits) Order 2009 &amp; Health Insurance (Health Insurance Plan) (Additional Benefits) Order 1988</td>
<td>• Hospital Visit Specialist - $1,004</td>
</tr>
<tr>
<td></td>
<td>• Hospital Visit GP - $792</td>
<td>• Hospital Visit Specialist - $1,004</td>
</tr>
<tr>
<td></td>
<td>• Obstetricians - $3,442</td>
<td>• Hospital Visit Specialist - $1,004</td>
</tr>
<tr>
<td><strong>Local Out-Patient Services</strong></td>
<td>Covered at 100%</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td><strong>Emergency Room Visits</strong></td>
<td>Covered at 100%</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td><strong>Diagnostic Imaging</strong></td>
<td>Covered at 100%</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td></td>
<td>• At SHB BHeC approved facility and fee schedule</td>
<td>• Diagnostic imaging includes MRI, CT Scan, Ultrasound, X-Rays</td>
</tr>
<tr>
<td><strong>Supplemental Diagnostic Imaging and Cardiac Diagnostics</strong></td>
<td>Not Covered</td>
<td>Covered at 80% at KEMH and BHeC approved providers.</td>
</tr>
<tr>
<td></td>
<td>• Health Insurance (FutureCare Plan) (Additional Benefits) Order 2009 &amp; Health Insurance (Health Insurance Plan) (Additional Benefits) Order 1988</td>
<td>Diagnostic imaging includes MRI, CT Scan, Ultrasound, X-Rays</td>
</tr>
<tr>
<td><strong>Laboratory Services</strong></td>
<td>• Labs performed at KEMH – covered at 100%</td>
<td>• Labs performed at KEMH – covered at 100%</td>
</tr>
<tr>
<td></td>
<td>• Supplemental – approved facilities, covered labs and fees</td>
<td>• Supplemental - approved facilities, covered labs and fees</td>
</tr>
<tr>
<td><strong>SHB Wellness Benefit</strong></td>
<td>Covered at 100%</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td></td>
<td>• E.g. Fall Prevention, Diabetes Counselling, Hypertension, Smoking Cessation, Asthma/COPD Education and Nutrition Consulting.</td>
<td>E.g. Fall Prevention, Diabetes Counselling, Hypertension, Smoking Cessation, Asthma/COPD Education and Nutrition Consulting.</td>
</tr>
<tr>
<td><strong>BHB Employed Specialists</strong></td>
<td>Covered at 100%</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td></td>
<td>• As per Bermuda Hospitals Board (BHB) (Hospital Fees) Regulations</td>
<td></td>
</tr>
<tr>
<td><strong>HIP</strong></td>
<td><strong>FutureCare Plans</strong></td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td></td>
</tr>
<tr>
<td><strong>Artificial Limbs and Appliances</strong>  &lt;br&gt;• Policyholder must have 12 months continuous active policy to be eligible for this benefit  &lt;br&gt;• At SHB BHeC approved facility</td>
<td><strong>$100,000 lifetime max</strong>  &lt;br&gt;Services at a high-level:  &lt;br&gt;• Registered Nurse Visits  &lt;br&gt;  o Wound care  &lt;br&gt;  o IV Therapy and associated drugs  &lt;br&gt;• Palliative Care</td>
<td><strong>$100,000 lifetime max</strong>  &lt;br&gt;Services at a high-level:  &lt;br&gt;• Registered Nurse Visits  &lt;br&gt;  o Wound care  &lt;br&gt;  o IV Therapy and associated drugs  &lt;br&gt;• Palliative Care</td>
</tr>
<tr>
<td><strong>Home Medical Services Benefit</strong>  &lt;br&gt;• Physician assessment and referral required  &lt;br&gt;• SHB BHeC approved providers and fee schedule.</td>
<td><strong>$100,000 lifetime max</strong>  &lt;br&gt;Services at a high-level:  &lt;br&gt;• Registered Nurse Visits  &lt;br&gt;  o Wound care  &lt;br&gt;  o IV Therapy and associated drugs  &lt;br&gt;• Palliative Care</td>
<td></td>
</tr>
<tr>
<td><strong>Kidney Transplant</strong></td>
<td><strong>$150,000 benefit for kidney transplant</strong></td>
<td><strong>$150,000 benefit for kidney transplant</strong></td>
</tr>
<tr>
<td><strong>Dialysis</strong>  &lt;br&gt;• At SHB BHeC approved facilities</td>
<td><strong>Covered at 100%</strong></td>
<td><strong>Covered at 100%</strong></td>
</tr>
<tr>
<td><strong>Anti-rejection Drugs</strong></td>
<td><strong>Covered at 100%</strong></td>
<td><strong>Covered at 100%</strong></td>
</tr>
<tr>
<td><strong>HID Supplemental Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>GP Office Visits</strong></td>
<td><strong>$42 per visit - max 4 visits per year</strong></td>
<td><strong>$46 per visit</strong></td>
</tr>
<tr>
<td><strong>Specialist Physician Visits</strong>  &lt;br&gt;• Includes urology at KEMH and in community</td>
<td><strong>$170 for two initial consults max/year</strong>  &lt;br&gt;<strong>$75 for three follow up visits max/year</strong></td>
<td><strong>$170 for two initial consults max/year</strong>  &lt;br&gt;<strong>$75 for three follow up visits max/year</strong></td>
</tr>
<tr>
<td><strong>Wellness Benefit</strong></td>
<td><strong>80% coverage per visit/session to a max of $35 per visit, up to 6 visits per year</strong>  &lt;br&gt;E.g. Asthma, nutrition, diabetes, lifestyle counseling, fall prevention and counseling for smoking cessation</td>
<td><strong>80% coverage per visit/session to a max of $35 per visit, up to 6 visits per year</strong>  &lt;br&gt;E.g. Asthma, nutrition, diabetes, lifestyle counseling, fall prevention and counseling for smoking cessation</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td><strong>Not Applicable</strong></td>
<td><strong>$2,000 per policy year maximum</strong>  &lt;br&gt;• 100% paid for generic drugs  &lt;br&gt;• 80% paid for brand name drugs</td>
</tr>
<tr>
<td><strong>Personal Home Care services:</strong>  &lt;br&gt;• Requires Prior Approval  &lt;br&gt;• Policyholder must have continuous active policy for 12 months prior to being eligible for this benefit</td>
<td><strong>$60,000 max per year which includes the following services and rates:</strong>  &lt;br&gt;• Personal Caregiver - $15 per hour (max 40 hours per week)  &lt;br&gt;• Skilled Caregiver - $25 per hour (max 14 hours per week)  &lt;br&gt;• Adult Day Care - $50 per day to a max of $200 for 7 days  &lt;br&gt;• Registered Nurse Visit - $75.00 per visit to a max 12 visits per policy year</td>
<td><strong>$60,000 max per year which includes the following services and rates:</strong>  &lt;br&gt;• Personal Caregiver - $15 per hour (max 40 hours per week)  &lt;br&gt;• Skilled Caregiver - $25 per hour (max 14 hours per week)  &lt;br&gt;• Adult Day Care - $50 per day to a max of $200 for 7 days  &lt;br&gt;• Registered Nurse Visit - $75.00 per visit to a max 12 visits per policy year</td>
</tr>
</tbody>
</table>
**Vision Benefit**
- Applicable either in Bermuda or Overseas

**HIP**
- Eye examination and prescribed eyewear – not covered.

**FutureCare Plans**
- Eye examination - $50 per policy year
- Prescribed Eyewear - $200 max per policy year

<table>
<thead>
<tr>
<th>Service</th>
<th>HIP</th>
<th>FutureCare Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group Psychotherapy Sessions</strong></td>
<td>Not Covered</td>
<td>$46 per visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>max 24 visits/year</td>
</tr>
<tr>
<td><strong>Clinical Psychologist Visit</strong></td>
<td>Not Covered</td>
<td>$78 per visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>12 visits per policy year</td>
</tr>
<tr>
<td><strong>Psychiatrist Visit</strong></td>
<td>Not Covered</td>
<td>$131 for initial</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$81 for follow-up visits</td>
</tr>
<tr>
<td><strong>Physiotherapy or Occupational Therapy Visit</strong></td>
<td>Not Covered</td>
<td>$35 per visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>max 12 visits per policy year</td>
</tr>
<tr>
<td><strong>Speech Therapy Session</strong></td>
<td>Not Covered</td>
<td>$42 per visit</td>
</tr>
<tr>
<td>Referral required from GP</td>
<td></td>
<td>max of 12 one-hour sessions per policy year</td>
</tr>
<tr>
<td><strong>Chiropodist Visit</strong></td>
<td>Not Covered</td>
<td>$41 per visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>max 6 visits per policy year</td>
</tr>
<tr>
<td><strong>Allergy Services</strong></td>
<td>Not Covered</td>
<td>$500 lifetime maximum</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Includes test and treatment</td>
</tr>
<tr>
<td><strong>Registered Nurse Home Visits</strong></td>
<td>See Personal Home Care and Home Medical Services benefits above</td>
<td>12 visits per year - ordered by a physician See Personal Home Care and Home Medical Services benefits above</td>
</tr>
<tr>
<td><strong>Physician Home visits</strong></td>
<td>$82 per visit</td>
<td>$82 per visit</td>
</tr>
<tr>
<td><strong>Overseas Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>60% coverage at HID preferred facility</td>
<td>75% coverage at HID preferred facility</td>
</tr>
<tr>
<td></td>
<td>50% coverage at a non-HID preferred facility</td>
<td>65% coverage at a non-HID preferred facility</td>
</tr>
<tr>
<td></td>
<td>If travelling abroad, only emergency treatment covered</td>
<td>If travelling abroad, only emergency treatment covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Referrals will be required with the exception if travelling abroad and a medical emergency arises</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Treatment must be medically necessary and not available in Bermuda.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Care coordinated through GMMI</td>
<td></td>
</tr>
<tr>
<td></td>
<td>See Overseas Section for additional details</td>
<td></td>
</tr>
</tbody>
</table>
Dental Benefits: Paid in Accordance with the Bermuda Dental Fee Schedule

<table>
<thead>
<tr>
<th>Basic Dental Services</th>
<th>Pre-Estimate required from your Dentist prior to undergoing extensive dental procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventative and Diagnostic</strong></td>
<td>• 75% of Fee Schedule&lt;br&gt;• Policy Year: Unlimited&lt;br&gt;• Lifetime: Unlimited&lt;br&gt;• 100% of Fee Schedule&lt;br&gt;• Policy Year: Unlimited&lt;br&gt;• Lifetime: Unlimited</td>
</tr>
<tr>
<td><strong>Exams, Consultations, Polishing, Scaling or Root Planing, Fluoride</strong></td>
<td>• 75% of Fee Schedule&lt;br&gt;• Policy Year: Unlimited&lt;br&gt;• Lifetime: Unlimited&lt;br&gt;• 100% of Fee Schedule&lt;br&gt;• Policy Year: $1,200.00 maximum&lt;br&gt;• Lifetime: Unlimited</td>
</tr>
<tr>
<td><strong>Surgical and Minor Restorative</strong></td>
<td>• 75% of Fee Schedule&lt;br&gt;• Policy Year: Unlimited&lt;br&gt;• Lifetime: Unlimited&lt;br&gt;• 100% of Fee Schedule&lt;br&gt;• Policy Year: Unlimited&lt;br&gt;• Lifetime: Unlimited</td>
</tr>
<tr>
<td><strong>Endodontics</strong></td>
<td>Not Applicable&lt;br&gt;Root Canal Services&lt;br&gt;• 100% of Fee Schedule&lt;br&gt;• Policy Year: Unlimited&lt;br&gt;• Lifetime: Unlimited</td>
</tr>
<tr>
<td><strong>Periodontic</strong></td>
<td>Not Applicable&lt;br&gt;Treatment of Gum Disease&lt;br&gt;• 50% of Fee Schedule&lt;br&gt;• Policy Year: $1,500.00 maximum&lt;br&gt;• Lifetime: Unlimited</td>
</tr>
<tr>
<td><strong>Major Restorative</strong></td>
<td>Not Applicable&lt;br&gt;Crowns, Inlays, Onlays, Dentures or Bridgework, Braces, Dental Implants and Related Procedures&lt;br&gt;• 80% of Fee Schedule&lt;br&gt;• Policy Year: $3,000.00 maximum&lt;br&gt;• Lifetime: Unlimited</td>
</tr>
</tbody>
</table>

Additional Benefit Information

*Standard Health Benefits:
All HID policies include basic Standard Health Benefits (SHB). The Standard Health Benefit is a list of basic benefits that are included in all Bermuda Health Insurance plans. These are generally in-patient or out-patient services provided at the King Edward Memorial Hospital or other facilities approved by the Bermuda Health Council. For a list of benefits and fees, please consult the Health Insurance (Standard Health Benefit) Regulations 1971 and the Bermuda Hospitals Board (Hospital Fees) Regulation on the Bermuda Laws Online website.

Supplemental Benefits:
The Supplemental Benefits covered as part of the HID plans include overseas treatment coverage, specialist visits, Wellness Benefit, Dental Benefits, top up coverage for Kidney transplant, and Personal Home Care Services. The Supplemental benefit also identifies what is not covered by the Plan. The HID Supplemental Benefits can be found in the HID Basic Benefits table above, and the Dental or Overseas Brochures. The legislation that governs these benefits can be found on the Bermuda Laws Online website in the Health Insurance (Health Insurance Plan) (Additional Benefits) Order 1988 and Health Insurance (FutureCare Plan) (Additional Benefits) Order 2009.
Eligibility and Premiums

<table>
<thead>
<tr>
<th>Plans</th>
<th>Eligibility</th>
<th>Monthly Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Persons under 65 or eligible for subsidized premiums*</td>
</tr>
<tr>
<td>Health Insurance Plan</td>
<td>For those 18 years and over.</td>
<td>$429.24</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$190</td>
</tr>
<tr>
<td></td>
<td>For persons between 0–18 years old OR up to 21 years old if registered full time in a local educational facility.</td>
<td></td>
</tr>
<tr>
<td>FutureCare Plan</td>
<td>For 65 years and older.</td>
<td>$500.14</td>
</tr>
</tbody>
</table>

*Please see Certificate of Entitlement page/guide for more information on subsidized premium requirements and Aged Subsidy coverage.

How Do I Enrol?

1. The applicant needs to determine which enrolment form to use.
   b. Individual un-employed – choose the Individual Voluntary form (FORM-CA13).
   c. Employed by a Group or Company (includes employees and un-employed spouses) – the Employer would choose the Group Accounts Enrolment Form (FORM-CA12).
   d. For parent enrolling dependent child (18 years or younger, or is 19-21 years and full-time student in Bermuda) – Choose the Youth Enrolment Form (FORM-CA18).
      i. Parents need to enrol their children at the same time that they enrol themselves in a HIP policy.
      ii. The child must be resident in Bermuda.
2. If you are 65 years or older, select which plan, HIP or FutureCare, you would like to enrol in.
3. Return the form and first month’s premium to the Health Insurance Department.
4. For subsequent premium payments, the premium is due the first of each month. The following payment options are available:
   a. In person at Health Insurance Department. Cash, Cheque and Debit/Credit cards accepted.
   b. By mail to Health Insurance Department. Cheques only
   c. By Bank transfer:
      i. Online premium payments (see section for setup instructions)
      ii. Direct debit by HID – Policyholder must fill out the form and submit to HID. See forms FORM-CA16 – Direct Debit Individual Form and FORM-CA17 – Direct Debit Group Form in Appendix A

*PLEASE NOTE: YOU MUST HAVE YOUR SOCIAL INSURANCE NUMBER AND PAYMENT FOR ANY ENROLLMENT TO BE PROCESSED.*
Certificate of Entitlement

What is a Certificate of Entitlement?
Certificate of Entitlement (COE) is a Government Subsidized Fund Benefit, for those whom are deemed eligible residents of Bermuda once they have turned the age of 65 years. The benefit pays a percentile of local hospitalized treatments and services (Standard Health Benefits) as well as becoming eligible for paying a reduced premium for HIP and FutureCare Health Insurance policies.

How am I deemed eligible?
Any person over the age of 65 years who has been a resident of Bermuda for a continuous period of not less than 10 years during the period of 20 years immediately preceding their 65th birthdate, whether they are insured or not. During those ten (10) years if you have been absent abroad for more than three (3) months in any year (other than for purposes of educational/vocational training or on holiday) you will then break your tenure of being deemed eligible. Therefor your eligibility timeframe will reinstate on your return.

What does this benefit cover?
For persons age 65 years to 74 years who qualify for a Certificate of Entitlement, 70% of the Standard Health Benefits such as hospital bed fees and/or tests are covered by Government. For persons 75 years and older who qualify, 80% of the Standard Health Benefits such as hospital bed fees and/or tests are covered by Government.

How do I apply?
Once you have turned 65 years you should receive an application along with your pension forms. Alternatively you can collect an application from the Health Insurance Department, the Department of Social Insurance or online from the Government Website www.gov.bm.

How do I transfer or cancel my policy with HID?
By using the FORM-CA02 – Policy Cancellation or Plan Transfer form, a policyholder can cancel their existing plan or transfer between the HIP and FutureCare plans.

Frequently Asked Questions:

What happens if I miss paying my premium?
For both Individuals and Groups, policies will be terminated at sixty (60) days of non-payment of premium. After the 30 of non-payment of premiums, HID sends out letters advising policyholders of their lapse in premium payment and that their claims will be denied. If the policyholder does not make their premium payment by the sixtieth (60th) day, their policy will be terminated. HID also sends notification at this point that their account is terminated.

My account is in lapsed status, but not terminated, and my claims are being denied. Can I pay the outstanding premium to bring my account back to good standing?
Yes, so long as it is prior to your account being terminated (account is overdue less than 59 days). Once your account is back in good standing, the denied claims can be resubmitted for adjudication.

If my policy was terminated due to non-payment of premium, can I re-enrol with HID at a later date?
Yes, but the Group or Individual would need to complete and re-submit new enrolment forms and information to HID. The new policy effective date will be the 1st of either the current month or the month following HID’s receipt of the application and first premium payment.
Can I have my new policy backdated to the termination date of my prior policy?
No. As per legislation, HID cannot back date the effective date of a policy.

If I have claims during the lapsed period between my old and new policies, are they covered? Can I be reimbursed?
No. During the lapsed period between the old and new HID policies, any claims incurred are the responsibility of the individual or employer. HID will not cover any claims with service dates during the lapsed period.

If I have a child on my policy and the policy is terminated due to missed premium payments, can I re-enrol my child?
No. Enrolment of child is only possible at the time of the parent’s initial enrolment.

What if I have a newborn?
Yes, you have 30 days from the child’s birth to enrol the child under your existing HIP plan.

What if my child was covered under another insurer, can I enrol them with HID?
If one parent has an existing HIP plan, yes. The child must be enrolled with HID within 30 days of the prior policy being terminated.

If my Employer has enrolled me in their Group plan, how do I know I am covered?
The Employer is required to provide a written statement to the employee with the name and address of the Insurer with whom the employee’s policy is with. This needs to include the start of coverage date and the policy number.

How much can the Employer deduct from my salary to pay towards my health premium?
The Employer is required to pay the total cost of the monthly premium payable however, they may deduct up to 50% of the monthly premium due for the employee, and their non-employed spouse if applicable, from the employee’s paycheck.

What does “non-employed spouse” mean?
“Non-Employed Spouse” means the lawfully married spouse of the employee. The spouse must reside in Bermuda in the same household as the employee.

What if my spouse is employed or self-employed?
If employed or self-employed, the spouse will need to basic health benefits coverage outside of the Group plan.

For more details on the duties of the Employer and Employee and penalties, please see Section III – Compulsory Health Insurance Scheme in the Health Insurance Act 1970 on the Bermuda Laws Online website.

If I need vision preserving surgery, would it be covered?
If an eye injury is related to chronic disease or trauma/injury, it is covered. HIP participants are covered to a maximum surgery benefit of $2,177. FutureCare participants are covered up to 75% of the surgery costs. Treatment must be received at an approved facility as per the Standard Health Benefits.

Additional References:
Legislation that governs HID can be found in Bermuda Laws Online (www.bermudalaws.bm).

- Bermuda Hospitals Board (Hospital Fees) Regulations 2015
- Bermuda Hospitals Board (Medical Staff) Regulations 1996
- Bermuda Hospitals Board (Medical and Dental Charges) Order 2015
Overseas Coverage.

Overseas treatment is a benefit provided by HIP and FutureCare under their respective Supplemental Benefit Orders. HID’s overseas benefit uses a preferred network of overseas providers (in-network) to help manage treatment costs. As such, the benefit coverage is different between facilities inside of HID’s preferred provider network versus those providers outside of our preferred provider network. The following grid shows the basic benefit coverage for each plan for facilities in the preferred network and outside.

<table>
<thead>
<tr>
<th>Plan</th>
<th>In HID’s Preferred Overseas Provider Network</th>
<th>Outside of HID’s Preferred Provider Network but Within GMMI’s Overall Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIP</td>
<td>60% of reasonable charges after discounts negotiated by GMMI</td>
<td>50% of reasonable charges after discounts negotiated by GMMI</td>
</tr>
<tr>
<td>FutureCare</td>
<td>75% of reasonable charges after discounts negotiated by GMMI</td>
<td>65% of reasonable charges after discounts negotiated by GMMI</td>
</tr>
</tbody>
</table>
HID’s list of preferred overseas provider are shown in the following table by main diagnosis category:

<table>
<thead>
<tr>
<th>USA / CANADA</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiology</strong></td>
<td></td>
</tr>
<tr>
<td>Lahey Clinic</td>
<td>Burlington, MA</td>
</tr>
<tr>
<td>Cleveland Clinic Hospital</td>
<td>Weston, FL</td>
</tr>
<tr>
<td>Johns Hopkins Hospital</td>
<td>Baltimore, MD</td>
</tr>
<tr>
<td>Mount Sinai Medical Center</td>
<td>Miami Beach, FL</td>
</tr>
<tr>
<td><strong>Orthopedics</strong></td>
<td></td>
</tr>
<tr>
<td>New England Baptist Hospital</td>
<td>Boston, MA</td>
</tr>
<tr>
<td>Newton-Wellesley Hospital</td>
<td>Boston, MA</td>
</tr>
<tr>
<td>Good Samaritan Medical Center</td>
<td>West Palm Beach, FL</td>
</tr>
<tr>
<td>Tufts Medical Center</td>
<td>Boston, MA</td>
</tr>
<tr>
<td>Toronto General Hospital / Toronto Western Hospital</td>
<td>Toronto, ON</td>
</tr>
<tr>
<td>Broward General Medical Center</td>
<td>Fort Lauderdale, FL</td>
</tr>
<tr>
<td>Emory St. Joseph Hospital</td>
<td>Atlanta, GA</td>
</tr>
<tr>
<td><strong>Oncology</strong></td>
<td></td>
</tr>
<tr>
<td>Doral Oncology</td>
<td>Doral, FL</td>
</tr>
<tr>
<td>21st Century Oncology</td>
<td>Pembroke Pines, FL</td>
</tr>
<tr>
<td>Princess Margaret Hospital</td>
<td>Toronto, ON</td>
</tr>
<tr>
<td>Cancer Treatment Centers of America</td>
<td>Various locations</td>
</tr>
<tr>
<td>Fox Chase Cancer Center</td>
<td>Philadelphia, PA</td>
</tr>
<tr>
<td>Lahey Clinic</td>
<td>Burlington, MA</td>
</tr>
<tr>
<td>Thomas Jefferson University Hospital</td>
<td>Philadelphia, PA</td>
</tr>
<tr>
<td><strong>Nephrology</strong></td>
<td></td>
</tr>
<tr>
<td>Faulkner Hospital</td>
<td>Boston, MA</td>
</tr>
<tr>
<td>Lahey Clinic</td>
<td>Burlington, MA</td>
</tr>
<tr>
<td>Mount Sinai Hospital</td>
<td>Toronto, ON</td>
</tr>
<tr>
<td>Cleveland Clinic Hospital</td>
<td>Weston, FL</td>
</tr>
<tr>
<td>Emory St. Joseph Hospital</td>
<td>Atlanta, GA</td>
</tr>
<tr>
<td><strong>Kidney Transplant</strong></td>
<td></td>
</tr>
<tr>
<td>Lahey Clinic</td>
<td>Burlington, MA</td>
</tr>
<tr>
<td>Johns Hopkins Hospital</td>
<td>Baltimore, MD</td>
</tr>
<tr>
<td><strong>Paediatrics</strong></td>
<td></td>
</tr>
<tr>
<td>IWK Health Center</td>
<td>Halifax, NS</td>
</tr>
<tr>
<td>Hospital for Sick Children</td>
<td>Toronto, ON</td>
</tr>
<tr>
<td>Children’s Hospital</td>
<td>Philadelphia, PA</td>
</tr>
<tr>
<td><strong>Trauma</strong></td>
<td></td>
</tr>
<tr>
<td>Broward General Medical Center</td>
<td>Fort Lauderdale, FL</td>
</tr>
<tr>
<td>Boston Medical Center</td>
<td>Boston, MA</td>
</tr>
<tr>
<td>Massachusetts General Hospital</td>
<td>Boston, MA</td>
</tr>
<tr>
<td>Thomas Jefferson University Hospital</td>
<td>Philadelphia, PA</td>
</tr>
<tr>
<td><strong>General</strong></td>
<td></td>
</tr>
</tbody>
</table>
HID uses an overseas care management company, Global Medical Management Inc. (GMMI) to assist with coordinating our policyholder’s overseas treatment. GMMI is available 24/7 and can assist with emergency assistance overseas, provide information about HID’s overseas preferred provider network. GMMI negotiate rates for treatment facilities both in HID’s preferred network and in the overall GMMI network. Policyholders who are referred for overseas treatment must contact GMMI to organize their treatment. The basic rules that govern HID’s overseas benefit are listed below. These apply to both the HIP and FutureCare plans:

1. The treatment must be medically necessary and not available in Bermuda.
2. Policyholder must have a referral from a Specialist or Physician.
3. GMMI must be contacted to organize care for the policyholder and negotiate reduced cost for care.

If policyholder is travelling abroad, only emergency care is covered. Emergency is defined as “an injury or illness that is acute and an immediate risk to a person’s life or long-term health”.

**HID Benefits Limits and Exclusions:**

1. Overseas treatment is limited to 45 days in-patient stay during a twelve (12) month period for the same diagnosis;
2. Overseas treatment is limited to in-patient and out-patient hospital treatment within the preferred network of treatment facilities;
3. Long-term care, custodial, or hospice care overseas is not covered;
4. Rehabilitation for drug or alcohol addiction overseas is not covered;
5. Airfare, air ambulance, hotel and transportation costs to and from the hospital are not covered for overseas treatment;
6. Cosmetic or plastic surgery are not covered unless necessary to correct traumatic injury;
7. Elective treatments, second opinions and experimental treatments are not covered;
8. Diagnostic services performed to satisfy the requirements for third parties is not covered;
9. Claims from medical providers or individuals must be submitted within 12 months of the treatment date, otherwise the claim is expired and will be rejected;
Appendix A: Forms
FORM-CA12 – Group Accounts Enrolment Form

Health Insurance Department
Health Insurance Plan / FutureCare Plan
Group Application Form

*All sections must be completed in their entirety
Please indicate if:
□ New Group
□ Group Re-enrolment
□ Group Information Change (only complete fields that have changes)

Section A: Employer’s Information

Name of Group:

Mailing Address:

Parish: Postal Code:

Number of Employees and Non-Employed Spouses:

Group Effective Date (dd/mm/yy): 1st Premium Due: (See Calculation Below)

Primary Contact Person: Phone #: Alternate Phone #: Email Address:

Name of Previous Insurer:

Effective Date (dd/mm/yy): Termination Date (dd/mm/yy): 

*Please note:
▪ The first premium is to be paid on enrolment. If first premium payment is made by cheque and there are insufficient funds when it is cashed, the policy will be put into lapsed status. Claims will be denied until the premium is paid.
▪ The premium is due on the 1st of each month. Failure to pay the premium within SIXTY DAYS will result in the cancellation of insurance coverage.

By signing below, I, _______________________________ (Employer’s Name), hereby certify that all information provided is complete and accurate. 

Employer’s Signature: _______________________________ Date (dd/mm/yy): 

FORM-CA12 – Group Accounts Enrolment Form V0.00
01 June 2017

Mailing Address: Health Insurance Department, P.O. Box HM 2160, Hamilton HM JX
Street Address: Sofia House, 2nd Floor, 40 Church Street, Hamilton HM 12
Phone: 441-295-8210 Fax: 441-295-8213 Website: www.gov.bm Email: hip@gov.bm
Section B: Employee Information

Employee's Name: ____________________________
(Mr./Mrs./Miss/Ms.) (First Name) ____________________________
(Middle Name) ____________________________ (Last Name) ____________________________

Employee's Address: ____________________________
Parish: ____________________________ Postal Code: ____________________________
Birthdate (dd/mm/yy): _______ / _______ / _______ Phone #: _______ - _______ Social Insurance #: ____________________________

Email: ____________________________

Marital Status: □ Single □ Married
Gender: □ Male □ Female
Health Plan: □ FutureCare □ HIP
Employee’s Start Date (dd/mm/yy): _______ / _______ / _______ Occupation: ____________________________

Section C: Non-Employed Spouse of Employee

Spouse’s Name: ____________________________
(Mr./Mrs./Miss/Ms.) (First Name) ____________________________
(Middle Name) ____________________________ (Last Name) ____________________________

Spouse’s Address: ____________________________
Parish: ____________________________ Postal Code: ____________________________
Birthdate (dd/mm/yy): _______ / _______ / _______ Phone #: _______ - _______ Social Insurance #: ____________________________

Email: ____________________________

Health Plan: □ FutureCare □ HIP Spouse Effective Date: _______ / _______ / _______ (Usually the same as Employee’s Start Date)

*Please make copies of this page for additional employees*

I, ____________________________, (Employee's Name), hereby certify that all information in Sections B and C (if applicable) provided is complete and accurate.

Employee’s Signature: ____________________________ Date (dd/mm/yy): _______ / _______ / _______
FORM-CA13 – Voluntary Application

Health Insurance Department
Voluntary Application for Enrolment

Plan Type: ☐ FutureCare ☐ HIP

☐ New Customer ☐ Re-Enrolment*

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

I declare that the information above is accurate to the best of my knowledge. I agree to share my health information between the Health Insurance Department and any healthcare providers or facilities for the purposes determining my healthcare needs, benefits and reimbursement of claims.

Signed: ____________________________ Date (dd/mm/yy): __________/________/________

Premium Payment: The first premium is to be paid on enrolment. If payment is made by cheque and there are insufficient funds when cashed, the policy will be put in lapsed status. Claims will be denied until premium payment is made. Subsequent premium payments are due the 1st of each month. Failure to pay the premium within SIXTY DAYS will result in cancellation of insurance coverage.
FORM-CA14 – Compulsory Application

Health Insurance Department
Compulsory Application for Enrolment

Plan Type: [ ] FutureCare [ ] HIP
[ ] New Customer [ ] Re-enrolment*

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 # (if applicable): ____________________________

Are you a resident of Bermuda? [ ] Yes [ ] No

*Please note: For Re-enrolments, a discussion with a Customer Service Representative is required.

Lapsed period: From Date (dd/mm/yy): ____________________________ To Date: (dd/mm/yy): ____________________________

Employment

Name or Business Name: ____________________________

Address: ____________________________

Telephone Number: ____________________________ Occupation: ____________________________

Employment Start Date (dd/mm/yy): ____________________________

Insurance Declaration

Previous Insurer: ____________________________

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

Have you had HIP or FutureCare Insurance before? [ ] Yes [ ] No

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

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

Premium Payment: The first premium is to be paid on enrolment. If payment is made by cheque and there are insufficient funds when cashed, the policy will be put in lapsed status. Claims will be denied until premium payment is made. Subsequent premium payments are due the 1st of each month. Failure to pay the premium within SIXTY DAYS will result in cancellation of insurance coverage.
FORM-CA18 – Youth Application Form

Health Insurance Department
Health Insurance Plan - Youth Application Form

Participant’s Name*: 

Group #: or Policy #: (**Please see note below)

Email Address: 

Please indicate if:
☐ New Dependant
☐ Information Change
(Only complete fields that have changes)

Dependant of Participant
(*Required)

*Dependant’s Name: Mr./Miss/Ms. (First Name) (Middle Name) (Last Name)

*Address: 

*Parish: 

*Phone #: 

*Birthdate (dd/mm/yyyy): / / 

*Age: 

Social Insurance Number: 

Effective Date: / / 

***It is a requirement to include documentation showing that the participant is a parent or guardian of the dependant (e.g. birth certificate, or court documents for legal guardian).

If the dependent is 19 to 21 years of age, the dependent must be enrolled in full time education in Bermuda. A letter from the Registrar must accompany this form.

I, ___________________________ (Participant’s Name), hereby certify that all the information provided above is complete and accurate.

Participant’s Signature: ___________________________ Date (dd/mm/yyyy): / / 

FORM-CA18 – Youth Accounts Enrolment Form V02.03
01 June 2017

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
Phone: 441-295-0210 Fax: 441-295-0213 Website: www.gov.bm Email: hip@gov.bm

MKT-CA10 HIP and FC Guide v01.00 August 2017
Health Insurance Department
Application for a Certificate of Entitlement
(for persons 65 years of age or older)

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: __________________________

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:

(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

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

______________________________

(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

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 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

FORM CA04 – Certificate of Entitlement Application V04.00
09 September 2014
# Health Insurance Department

## Health Insurance Plan / FutureCare Plan

### Policy Cancellation / Plan Transfer Form

#### Policyholder Details (Please Print)......

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

- **Mailing Address:**

- **Parish:**

- **Postal Code:**

- **Policy Number:**

- **Group Number:**

- **Date of Birth (dd/mm/yy):**

- **Telephone Number:**

- **Email Address:**

- **Requesting:**
  - [ ] Policy Cancellation
  - [ ] Plan Transfer

#### Policy Cancellation Details (to be completed for Policy Cancellation request)

- **Policyholder Deceased**
  - **Date of Death (dd/mm/yy):**

- **Power of Attorney / Next of Kin**
  - **Tel No.:**

- **Name:**

- **Address:**

- **Parish:**

- **Postal Code:**

#### Terminated Employment

- **Last Day of Work (dd/mm/yy):**

#### No Longer a Bermudian Resident

- **Date of Departure (dd/mm/yy):**

#### Other Insurance Coverage in Force

- **Name of Insurer:**

- **Effective Date (dd/mm/yyyy):**

#### Unable to pay

- **Cancellation Date (dd/mm/yyyy):**

#### Other

- **Cancellation Date (dd/mm/yyyy):**

#### Plan Transfer Details (to be completed for Plan Transfer request. Enrolment Form to be completed and attached.)

- **Plan transferring from:**
  - [ ] HIP
  - [ ] FutureCare

- **Plan transferring to:**
  - [ ] HIP
  - [ ] FutureCare

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

- **Signed:**

- **Date (dd/mm/yy):**

---

**Mailing Address:** Health Insurance Department, P.O. Box HM 2160, Hamilton HM 12

**Street Address:** Sofia House, 2nd Floor, 48 Church Street, Hamilton HM 12

**Phone:** 441-295-9210  **Fax:** 441-295-9213  **Website:** www.hip.gov.bm  **Email:** hip@gov.bm

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Page 21 of 26
FORM-CA05 – Policyholder Information Change Form

Health Insurance Department
Health Insurance Plan / FutureCare Plan
Policyholder Information Change Request

* Supporting documentation and approval are required for a Name Change, Date of Birth correction or request to address cheques to individuals other than the name listed on the account

Name: ____________________________
(Mr., Mrs., Miss, Ms.)    (First Name)
(Middle Name)    (Last Name)

Policy Number: ____________    Group Number (if applicable): ____________

Policyholder’s New Information (if changed)

Name: ____________________________
(Mr., Mrs., Miss, Ms.)    (First Name)
(Middle Name)    (Last Name)

Mailing Address: ____________________________

Parish: ____________________________    Postal Code: ____________

Policy Number: ____________

Date of Birth (dd/mm/yy): ____________

Telephone Number: ____________________________
(Home)    (Work)    (Other)

Email Address: ____________________________
(Please Print)

Supporting Documentation (Please check appropriate box):

☐ Birth Certificate    ☐ Marriage Certificate    ☐ Driver’s License
☐ Power of Attorney    ☐ Other ____________________________
(Please describe)

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

Signed: ____________________________    Date (dd/mm/yy): ____________

When completed, this form should be returned with supporting documentation to:
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
Phone: 441-295-5210 Fax: 441-295-5213 Website: www.hip.gov.bm Email: hip@gov.bm

FORM-CA05 – Policyholder Information Change Request V05.00
34 March 2014
Health Insurance Department
Direct Debit Individual Request Form
Please complete this form to subscribe to monthly direct debit billing for Health Insurance Department premium payments.

Policyholder Details* (Please Print):
Payment made on behalf of a different Policyholder: ☐ Yes ☐ No
If yes, enter that participant’s information in the Policyholder details.

Name: __________________________
(Mr./Mrs./Miss./Ms.) __________________________
(First Name) __________________________
(Middle Name) __________________________
(Last Name) __________________________

Mailing Address: __________________________

Parish: __________________________
Postal Code: __________________________
Policy Number: __________________________

Date of Birth (dd/mm/yy): __/__/____
Telephone Number: ____________

☐ New Request for Direct Debit
☐ Change to Existing Direct Debit Record
☐ Cancellation
* All fields are mandatory

Payer Details: Please provide the following information.

Name on Bank Account to be Debited: __________________________

Bank Name (Bermuda Banks Only): __________________________

Bank Account Number (Bermuda Banks Only): __________________________
(For accuracy, proof of account name and number portion of bank statement must be attached to this form)

Account Type (Chequing or Savings): __________________________
Currency Type: Bermuda Dollars Only

Terms & Conditions:
1. Health Insurance Department (HID) will debit the monthly premium, as noted below, on the first business day of each month this request is in effect. If the first day of the month falls on a weekend or government holiday, the funds will be debited on the next working day.
2. In the event of Non-Sufficient Funds (NSF), or other errors, at the time of Direct Debit, the Health Insurance Department (HID) will be notified by the bank. Any service fees associated with NSF error will be the policyholder’s or payer’s responsibility. When this occurs, the policyholder/payer will be required to pay their account balance through other means. Direct Debit will resume with the next billing period.

FORM CA16 – Direct Debit Individual Form V04.00
01 June 2017

Mailing Address: Health Insurance Department, P.O. Box HM 2180, Hamilton HM 1X
Street Address: Sofia House, 2nd Floor, 48 Church Street, Hamilton HM 12
Phone: 441-295-9210 Fax: 441-295-9213 Website: www.gov.bm Email: hip@gov.bm
3. Only acceptable account currency is Bermuda dollars. HID will not accept any other currency type.

4. The policyholder/payer is responsible for notifying HID of changes to their bank account information by the 15th day of the month prior to the next scheduled Direct Debit on the account. Failure to do so may result in a lapse in payment and/or potential termination of their coverage.

5. In order to cancel this agreement, HID must be notified in writing by the 15th day of the month prior to the next scheduled Direct Debit on the policyholder/payer's account.

6. If there are legislative changes to the monthly premiums, this will automatically be updated in the policyholder's Direct Debit Record. The new amount will be debited from the policyholder/payer's account as of the effective date mentioned in legislation.

7. If the policyholder's policy is terminated, either by their request or by lapse in payment, Direct Debit will cease to pull the funds from the account specified above. Upon re-enrollment of the policyholder with HID, the policyholder/payer will need to re-apply for Direct Debit.

8. HID reserves the right to remove your account from Direct Debit for any reason, including but not limited to issues that prevent or complicate the payment of funds from your bank.

Acknowledgement:
By signing the Monthly Premium Payment Direct Debit Request form, I/we agree to the terms and conditions noted above and hereby authorize Health Insurance Department to automatically debit my Bermuda bank account for the amount due on my Health Insurance account on the date the debit is scheduled, until this authorization is revoked.

Signature: ___________________________ Date (dd/mm/yy): ____________

[If required]
Signature: ___________________________ Date (dd/mm/yy): ____________

For Office Use:
The amount of __________________________ (equivalent of one month's premium payment) will be debited on the first business day of each month this request is in effect. In the event that the first of the month falls on the weekend or holiday, the funds will be debited on the next working day.

The first debit will be made on ______/_____/_______ (DD/MM/YYYY).

In the event of requested termination of policy or this offering, the termination effective date will be ________________ (DD/MM/YYYY).
FORM-CA17 – Direct Debit Group Form

Health Insurance Department
Direct Debit Group Request Form
Please complete this form to subscribe to monthly direct debit billing for Health insurance Department premium payments.

Group Details *(Please Print)*:

Name of Group:

Mailing Address:

Parish:  
Postal Code:

Primary Contact Person:  
Telephone Number:

Email Address:  
Group Number:

☐ New Request for Direct Debit
☐ Change to Existing Direct Debit Record
☐ Cancellation
*all fields are mandatory

Employer Bank Details (Payer): Please provide the following information.

Name on Bank Account to be Debit:

Bank Name (Bermuda Banks Only):

Bank Account Number (Bermuda Banks Only):  
(For accuracy, proof of account name and number portion of bank statement must be attached to this form)

Account Type (Chequing or Savings):

Currency Type:  
Bermuda Dollars Only

☐ A Letter of Authorization (LOA) from the Employer to validate authorized Signatories or the person(s) who can request this service on behalf of the Business/Group is attached or already filed with the Health Insurance Department

Terms & Conditions:

1. Health Insurance Department (HID) will debit the balance due amount shown on your monthly Billing Statement on the first business day of each month this request is in effect. If the first day of the month falls on a weekend or government holiday, the funds will be debited on the next working day.

2. In the event of Non-Sufficient Funds (NSF), or other errors, at the time of Direct Debit, the HID will be notified by the bank. Any service fees associated with NSF errors will be the Employer’s responsibility. When this occurs, the Employer will be required to pay their account balance through other means. Direct Debit will resume with the next billing period.

3. Only acceptable account currency is Bermuda dollars. HID will not accept any other currency type.

4. The Employer is responsible for notifying HID of changes to the number of members covered under the Group’s policy by the 15th day of the month prior to the next scheduled direct debit on the Employer’s account. Failure to do so may result in additional payments, lapse in payment or termination of coverage.
5. In order to cancel this agreement, HID must be notified in writing by the 15th day of the month prior to the next scheduled Direct Debit on the Group’s account.
6. The Employer is responsible for notifying HID of changes to their bank account information by the 15th day of the month prior to the next scheduled Direct Debit on the Employer’s account. Failure to do so may result in a lapse in payment and/or potential termination of their Group’s coverage.
7. If there are legislative changes to the monthly premiums, this will automatically be updated in the Employer’s Direct Debit Record. The new amount will be debited from the Employer’s account as of the effective date mentioned in legislation.
8. If the Group’s policy is terminated, either by your request or by lapse in payment, Direct Debit will cease to pull the funds from the account specified above. Upon re-enrollment of the Group policy with HID, the Employer will need to re-apply for Direct Debit.
9. HID reserves the right to remove your account from Direct Debit for any reason, including but not limited to issues that prevent or complicate the payment of funds from your bank.

Acknowledgement:
By signing the Monthly Premium Payment Direct Debit Request form, I/we agree to the terms and conditions noted above and hereby authorize Health Insurance Department to automatically debit my Bermuda bank account for the amount due on my Health Insurance account on the date the debit is scheduled, until this authorization is revoked.

Signature 1: ___________________________ Date (dd/mm/yy): __________ / __________ / __________

Print Name: ___________________________ Company Name: ___________________________

Position: _____________________________

[If Required]
Signature 2: ___________________________ Date (dd/mm/yy): __________ / __________ / __________

Print Name: ___________________________ Company Name: ___________________________

Position: _____________________________

For Office Use:
The first debit will be made on _____/_____/______ (DD/MM/YYYY).
In the event of requested termination of policy or this offering, the termination effective date will be __________ (DD/MM/YYYY)

Effective Date (dd/mm/yy): __________

Processed By and Date (dd/mm/yy): __________________________

HID Manager Signature

________________________

________________________