Health Insurance Department:

Health Insurance and FutureCare Plan Guide

GOVERNMENT OF BERMUDA

Ministry of Health
Health Insurance Department

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Contents

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:

	HIP	**FutureCare Plans**
Local In-Patient (King Edward Memorial Hospital (KEMH) / Mid-Atlantic Wellness Institute (MAWI))		
Hospitalizations • As per Bermuda Hospitals Board (BHB) (Hospital Fees) Regulations	All costs associated with overnight stay. E.g. room and board, nursing • KEMH - Covered at 100% • MAWI – Covered at 100% up to 40 days in-patient stay • New born delivery – covered at 100%	All costs associated with overnight stay. E.g. room and board, nursing • KEMH - Covered at 100% • MAWI – Covered at 100% up to 40 days in-patient stay
Profession Physicians Fees • HIP fees based on Bermuda Hospitals Board (Medical and Dental Charges) Order 2015 • Health Insurance (FutureCare Plan) (Additional Benefits) Order 2009 & Health Insurance (Health Insurance Plan) (Additional Benefits) Order1988	During hospitalization (Maximums per admission) • Surgery - $2,114 • Anesthetist - $1,171 • Internal Medicine - $1,643 • Hospital Visit Specialist - $1,004 • Hospital Visit GP - $792 • Obstetricians - $3,442 • Caesarean Delivery - $3,442 • SVD (Vaginal) Care/Delivery - $3,442 • Caesarean delivery fee for on-call delivery - $3,442 • SVD fee for on-call delivery - $3,442 • Suction D&C (TOP) - $3,442	During hospitalization (Maximums per admission) • 75% reimbursement per admission
Local Out-Patient Services (KEMH and Standard Health Benefit (SHB) Approved Providers***)**		
Emergency Room Visits	Covered at 100%	Covered at 100%
Diagnostic Imaging • At SHB BHeC approved facility and fee schedule	Covered at 100% • Diagnostic imaging includes MRI, CT Scan, Ultrasound, X-Rays	Covered at 100% • Diagnostic imaging includes MRI, CT Scan, Ultrasound, X-Rays
Supplemental Diagnostic Imaging and Cardiac Diagnostics • Health Insurance (FutureCare Plan) (Additional Benefits) Order 2009	Not Covered	Covered at 80% at KEMH and BHeC approved providers.
Laboratory Services • At SHB BHeC approved facility and at the approved SHB fee schedule	• Labs performed at KEMH – covered at 100% • Supplemental – approved facilities, covered labs and fees	• Labs performed at KEMH – covered at 100% • Supplemental - approved facilities, covered labs and fees

	HIP	FutureCare Plans
SHB Wellness Benefit • Via BHB D.R.E.A.M. Centre and Bermuda Diabetes Association • At SHB approved fee schedule	Covered at 100% • E.g. Fall Prevention, Diabetes Counselling, Hypertension, Smoking Cessation, Asthma/COPD Education and Nutrition Consulting.	Covered at 100% • E.g. Fall Prevention, Diabetes Counselling, Hypertension, Smoking Cessation, Asthma/COPD Education and Nutrition Consulting.
BHB Employed Specialists • As per Bermuda Hospitals Board (BHB) (Hospital Fees) Regulations	Covered at 100% • Benefit excludes Urology	Covered at 100% • Benefit excludes Urology
Artificial Limbs and Appliances • Policyholder must have 12 months continuous active policy to be eligible for this benefit • At SHB BHeC approved facility	$100,000 lifetime max	$100,000 lifetime max

Home Medical Services Benefit
• Physician assessment and referral required
• SHB BHeC approved providers and fee schedule.
	Services at a high-level:
	• Registered Nurse Visits
	  ○ Wound care
	  ○ IV Therapy and associated drugs
	• Palliative Care
		Services at a high-level:
		• Registered Nurse Visits
		  ○ Wound care
		  ○ IV Therapy and associated drugs
		• Palliative Care

Kidney Transplant	$150,000 benefit for kidney transplant	$150,000 benefit for kidney transplant
Dialysis • At SHB BHeC approved facilities	Covered at 100%	Covered at 100%
Anti-rejection Drugs	Covered at 100%	Covered at 100%
HID Supplemental Benefits		
GP Office Visits	$42 per visit - max 4 visits per year	$46 per visit

Specialist Physician Visits	• $170 for two initial consults max/year
	• $75 for three follow up visits max/year
	  ○ Includes oncology physician services at Bermuda Cancer and Health
		• $170 for two initial consults max/year
		• $75 for three follow up visits max/year
		  ○ Includes oncology physician services at Bermuda Cancer and Health

Wellness Benefit	80% coverage per visit/session to a max of $35 per visit, up to 6 visits per year E.g. Asthma, nutrition, diabetes, lifestyle counseling, fall prevention and counseling for smoking cessation	80% coverage per visit/session to a max of $35 per visit, up to 6 visits per year E.g. Asthma, nutrition, diabetes, lifestyle counseling, fall prevention and counseling for smoking cessation

	HIP	FutureCare Plans
Prescription Drugs	Not Applicable	$2,000 per policy year maximum • 100% paid for generic drugs • 80% paid for brand name drugs
Personal Home Care services: • Requires Prior Approval • Policyholder must have continuous active policy for 12 months prior to being eligible for this benefit	$60,000 max per year which includes the following services and rates: • Personal Caregiver - $15 per hour (max 40 hours per week) • Skilled Caregiver - $25 per hour (max 14 hours per week) • Adult Day Care - $50 per day to a max of $200 for 7 days • Registered Nurse Visit - $75.00 per visit to a max 12 visits per policy year	$60,000 max per year which includes the following services and rates: • Personal Caregiver - $15 per hour (max 40 hours per week) • Skilled Caregiver - $25 per hour (max 14 hours per week) • Adult Day Care - $50 per day to a max of $200 for 7 days • Registered Nurse Visit - $75.00 per visit to a max 12 visits per policy year
Radiation Treatments for Cancer Care	• Local - Covered at 100% • Overseas o HID preferred network – covered at 60% o Non-HID preferred network – covered at 50%	• Local – Covered at 100% • Overseas o HID preferred network – covered at 75% o Non-HID preferred network – covered at 65%
Vision Benefit • Applicable either in Bermuda or Overseas	• Eye examination and prescribed eyewear – not covered.	• Eye examination - $50 per policy year • Prescribed Eyewear - $200 max per policy year
Group Psychotherapy Sessions	Not Covered	$46 per visit • max 24 visits/year
Clinical Psychologist Visit	Not Covered	$78 per visit • 12 visits per policy year
Psychiatrist Visit	Not Covered	$131 for initial • $81 for follow-up visits
Physiotherapy or Occupational Therapy Visit	Not Covered	$35 per visit • max 12 visits per policy year
Speech Therapy Session Referral required from GP	Not Covered	$42 per visit • max of 12 one-hour sessions per policy year
Chiropodist Visit	Not Covered	$41 per visit • max 6 visits per policy year
Allergy Services	Not Covered	$500 lifetime maximum • Includes test and treatment
Registered Nurse Home Visits	See Personal Home Care and Home Medical Services benefits above	12 visits per year - ordered by a physician See Personal Home Care and Home Medical Services benefits above
Physician Home visits	$82 per visit	$82 per visit

	HIP	FutureCare Plans
Overseas Treatment		

• Referrals will be required with the exception if travelling aboard and a medical emergency arises
• Treatment must be medically necessary and not available in Bermuda.
• Care coordinated through GMMI
• See Overseas Section for additional details
	• 60% coverage at HID preferred facility
	• 50% coverage at a non-HID preferred facility
	  ○ If travelling abroad, only emergency treatment covered
		• 75% coverage at HID preferred facility
		• 65% coverage at a non-HID preferred facility
		  ○ If travelling abroad, only emergency treatment covered

Dental Benefits: Paid in Accordance with the Bermuda Dental Fee Schedule		
Basic Dental Services:	**Pre-Estimate required from your Dentist prior to undergoing extensive dental procedures**	
Preventative and Diagnostic	• 75% of Fee Schedule • Policy Year: Unlimited • Lifetime: Unlimited	• 100% of Fee Schedule • Policy Year: Unlimited • Lifetime: Unlimited
Exams, Consultations, Polishing, Scaling or Root Planing, Fluoride	• 75% of Fee Schedule • Policy Year: Unlimited • Lifetime: Unlimited	• 100% of Fee Schedule • Policy Year: $1,200.00 • Lifetime: Unlimited
Surgical and Minor Restorative	• 75% of Fee Schedule • Policy Year: Unlimited • Lifetime: Unlimited	• 100% of Fee Schedule • Policy Year: Unlimited • Lifetime: Unlimited
Endodontics	Not Applicable	Root Canal Services • 100% of Fee Schedule • Policy Year: Unlimited • Lifetime: Unlimited
Periodontic	Not Applicable	Treatment of Gum Disease • 50% of Fee Schedule • Policy Year: $1,500.00 • Lifetime: Unlimited
Major Restorative	Not Applicable	Crowns, Inlays, Onlays, Dentures or Bridgework, Braces, Dental Implants and Related Procedures • 80% of Fee Schedule • Policy Year: $3,000.00 • Lifetime: Unlimited

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

Plans	Eligibility	Monthly Premiums	
		Persons under 65 or eligible for subsidized premiums*	Persons over 65 not eligible for subsidized premiums*
Health Insurance Plan	For those 18 years and over.	$429.24	$1,104.78
	For persons between 0–18 years old OR up to 21 years old if registered full time in a local educational facility.	$190	N/A
FutureCare Plan	For 65 years and older.	$500.14	$1,498.48

* ***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.
    a. Individual Self-Employed – choose Individual Compulsory form (FORM-CA14).
    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.
    a. Apply for Certificate of Entitlement (Aged Subsidy) if not yet enrolled (FORM-CA04 – Certificate of Entitlement Application). See COE section for details.
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 Heath 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 (60^{th}) 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.

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.

Plan	In HID's Preferred Overseas Provider Network	Outside of HID's Preferred Provider Network but Within GMMI's Overall Network
HIP	60% of reasonable charges after discounts negotiated by GMMI	50% of reasonable charges after discounts negotiated by GMMI
FutureCare	75% of reasonable charges after discounts negotiated by GMMI	65% of reasonable charges after discounts negotiated by GMMI

HID's list of preferred overseas provider are shown in the following table by main diagnosis category:

USA / CANADA	**Location**
Cardiology	
Lahey Clinic	Burlington, MA
Cleveland Clinic Hospital	Weston, FL
Johns Hopkins Hospital	Baltimore, MD
Mount Sinai Medical Center	Miami Beach, FL
Orthopedics	
New England Baptist Hospital	Boston, MA
Newton-Wellesley Hospital	Boston, MA
Good Samaritan Medical Center	West Palm Beach, FL
Tufts Medical Center	Boston, MA
Toronto General Hospital / Toronto Western Hospital	Toronto, ON
Broward General Medical Center	Fort Lauderdale, FL
Emory St. Joseph Hospital	Atlanta, GA
Oncology	
Doral Oncology	Doral, FL
21st Centery Oncology	Pembroke Pines, FL
Princess Margaret Hospital	Toronto, ON
Cancer Treatment Centers of America	Various locations
Fox Chase Cancer Center	Philadelphia, PA
Lahey Clinic	Burlington, MA

Thomas Jefferson University Hospital	Philadelphia, PA
Nephrology	
Faulkner Hospital	Boston, MA
Lahey Clinic	Burlington, MA
Mount Sinai Hospital	Toronto, ON
Cleveland Clinic Hospital	Weston, FL
Emory St. Joseph Hospital	Atlanta, GA
Kidney Transplant	
Lahey Clinic	Burlington, MA
Johns Hopkins Hospital	Baltimore, MD
Paediatrics	
IWK Health Center	Halifax, NS
Hospital for Sick Children	Toronto, ON
Children's Hospital	Philadelphia, PA
Trauma	
Broward General Medical Center	Fort Lauderdale, FL
Boston Medical Center	Boston, MA
Massachusetts General Hospital	Boston, MA
Thomas Jefferson University Hospital	Philadelphia, PA
General	
Faulkner Hospital	Boston, MA
Lahey Clinic	Burlington, MA
Mount Sinai Hospital	Toronto, ON
Toronto General Hospital / Toronto Western Hospital	Toronto, ON
Good Samaritan Medical Center	West Palm Beach, FL
Broward General Medical Center	Fort Lauderdale, FL
Emory St. Joseph Hospital	Atlanta, GA
United Kingdom	
Bupa Cromwell Hospital	
King's College Hospital	
Royal Brompton & Harefield	

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. The following two items are exceptions to this rule:
    a. Radiation treatment is covered overseas according to the policyholder's plan and facility/network used.
    b. FutureCare policyholder vision benefits are available overseas.

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;

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
- Health Insurance Act 1970
- Health Insurance (AOA) Regulations 1971
- Health Insurance (Approved Schemes) Regulations 1971
- Health Insurance (Artificial Limbs and Appliances) Regulations 1971
- Health Insurance (Certificate of Entitlement) Regulations 1971
- Health Insurance (Cover) Regulations 1971
- Health Insurance (Double Cover) Regulations 1971
- Health Insurance (Exemption) Regulations 1971
- Health Insurance (FutureCare Plan) (Enrolment) Order 2011
- Health Insurance (FutureCare Plan) (Premium) Order 2015
- Health Insurance (FutureCare Plan) (Additional Benefits) Order 2009
- Health Insurance (HIP) (E) Rules 1987
- Health Insurance (Health Insurance Plan) (Additional Benefits) Order 1988
- Health Insurance (Health Insurance Plan) (Premium) Order 2015
- Health Insurance (Health Service Providers and Insurers) (Claims) Regulations 2012

- Health Insurance (IOR) Regulations 1971
- Health Insurance (Licensing of Insurers) Regulations 1971
- Health Insurance (MB) Regulations 1971
- Health Insurance (Mental Illness, Alcohol and Drug Abuse) Regulations 1973
- Health Insurance (Mutual Re-Insurance Fund) (Prescribed Sum) Order 2014
- Health Insurance (PFSP) Regulations 1971
- Health Insurance (Plans) Regulations 1987
- Health Insurance (Standard Health Benefit) Regulations 1971
- Health Insurance (Statistical Reports) Regulations 2010

Appendix A: Forms

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

FOR OFFICIAL USE
Approve By and Date (dd/mm/yy) _____
Processed by CSR and Date (dd/mm/yy) _____
No. of Members: _____
Exising Group: _____

*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 V06.00
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: 441-295-9210 **Fax:** 441-295-9213 **Website:** www.gov.bm **Email:** hip@gov.bm

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

FOR OFFICIAL USE

Employee's Effective Date
(DD/MM/YY): _____

Existing Group Name:

Group #:

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:
(If different from Employee'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 CA12 – Group Accounts Enrolment Form V06.00
01 June 2017

FORM-CA13 – Voluntary Application

FOR OFFICIAL USE

Policy Number: ____________________

Effective Date (d/m/y): ____________________

Existing AR Number if Re-Enrolment:

____

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

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 CA13 – Voluntary Application V06.00
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: 441-295-9210 **Fax:** 441-295-9213 **Website:** www.gov.bm **Email:** hip@gov.bm

Health Insurance Department
Compulsory
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-instatement: _____

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 # (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.

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

Form: CA14 – Compulsory Application V05.00
01 June 2017

FORM-CA18 – Youth Application Form

Health Insurance Department
Health Insurance Plan - Youth Application Form

FOR OFFICIAL USE

Approved By and Date (DD/MM/YY):

Processed by CSR and Date (DD/MM/YY):

No. of Members:

Existing Group #:

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: *Postal Code:

*Phone #: -

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

FORM CA18 – Youth Accounts Enrolment Form V02.00
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: 441-295-9210 **Fax:** 441-295-9213 **Website:** www.gov.bm **Email:** hip@gov.bm

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: _____

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:

		Check One Yes	Check One No	
(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? ◯ ◯ [ ]

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 V05.00
09 September 2017

FORM-CA02 – Policy Cancellation / Plan Transfer Form

Health Insurance Department
Health Insurance Plan / FutureCare Plan
Policy Cancellation / Plan Transfer Form

FOR OFFICIAL USE

Effective Date (dd/mm/yy): _____

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

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): / /
(Please attach copy of Death Certificate, Obituary or Memorial notice)

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/yy): / /

☐ Unable to pay Cancellation Date (dd/mm/yy): / /

☐ Other Cancellation Date (dd/mm/yy): / /

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

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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 JX
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

FORM-CA05 – Policyholder Information Change Form

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

FOR OFFICIAL USE ONLY:
Processed by CSR and Date (d/m/y): _____
*Approved by and Date (d/m/y): _____

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

FORM CA05 – Policyholder Information Change Request V05.00
25 March 2015

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 1/2

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

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:

Effective Date (dd/mm/yy):
_____

Processed By and Date (dd/mm/yy):
_____
HID Manager Signature
_____

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 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

☐ 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.

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

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 _____