Health Insurance Department:

Health Insurance and FutureCare Plan Guide

Ministry of Health
Health Insurance Department

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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>Local In-Patient (King Edward Memorial Hospital (KEMH) / Mid-Atlantic Wellness Institute (MAWI))</th>
<th>HIP</th>
<th>FutureCare Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospitalizations</strong></td>
<td>All costs associated with overnight stay. E.g. room and board, nursing</td>
<td></td>
</tr>
<tr>
<td>• As per Bermuda Hospitals Board (BHB) (Hospital Fees) Regulations</td>
<td>• KEMH - Covered at 100%</td>
<td>• KEMH - Covered at 100%</td>
</tr>
<tr>
<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>
<td></td>
</tr>
<tr>
<td>• New born delivery – covered at 100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Profession Physicians Fees</strong></td>
<td>During hospitalization (Maximums per admission)</td>
<td>During hospitalization (Maximums per admission)</td>
</tr>
<tr>
<td>• HIP fees based on Bermuda Hospitals Board (Medical and Dental Charges) Order 2015</td>
<td>• Surgery - $2,114</td>
<td>• 75% reimbursement per admission</td>
</tr>
<tr>
<td>• Health Insurance (FutureCare Plan) (Additional Benefits) Order 2009 &amp; Health Insurance (Health Insurance Plan) (Additional Benefits) Order 1988</td>
<td>• Anesthetist - $1,171</td>
<td></td>
</tr>
<tr>
<td>• Internal Medicine - $1,643</td>
<td>• Hospital Visit Specialist - $1,004</td>
<td></td>
</tr>
<tr>
<td>• Hospital Visit GP - $792</td>
<td>• Obstetricians - $3,442</td>
<td></td>
</tr>
<tr>
<td>• Caesarean Delivery - $3,442</td>
<td>• SVD (Vaginal) Care/Delivery - $3,442</td>
<td></td>
</tr>
<tr>
<td>• SVD fee for on-call delivery - $3,442</td>
<td>• Caesarean delivery fee for on-call delivery - $3,442</td>
<td></td>
</tr>
<tr>
<td>• Suction D&amp;C (TOP) - $3,442</td>
<td>• SVD (Vaginal) Care/Delivery - $3,442</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Local Out-Patient Services (KEMH and Standard Health Benefit (SHB) Approved Providers*)</th>
<th>HIP</th>
<th>FutureCare Plans</th>
</tr>
</thead>
<tbody>
<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>• At SHB BHeC approved facility and fee schedule</td>
<td>• Diagnostic imaging includes MRI, CT Scan, Ultrasound, X-Rays</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>• Health Insurance (FutureCare Plan) (Additional Benefits) Order 2009</td>
<td></td>
<td></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>• At SHB BHeC approved facility and at the approved SHB fee schedule</td>
<td>• Supplemental – approved facilities, covered labs and fees</td>
<td>• Supplemental - approved facilities, covered labs and fees</td>
</tr>
</tbody>
</table>
**SHB Wellness Benefit**
- Via BHB D.R.E.A.M. Centre and Bermuda Diabetes Association
- At SHB approved fee schedule

<table>
<thead>
<tr>
<th>HIP</th>
<th>FutureCare Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered at 100%</td>
<td>Covered at 100%</td>
</tr>
<tr>
<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>
</tbody>
</table>

**BHB Employed Specialists**
- As per Bermuda Hospitals Board (BHB) (Hospital Fees) Regulations

<table>
<thead>
<tr>
<th>HIP</th>
<th>FutureCare Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered at 100%</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td>Benefit excludes Urology</td>
<td>Benefit excludes Urology</td>
</tr>
</tbody>
</table>

**Artificial Limbs and Appliances**
- Policyholder must have 12 months continuous active policy to be eligible for this benefit
- At SHB BHeC approved facility

<table>
<thead>
<tr>
<th>HIP</th>
<th>FutureCare Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services at a high-level:</td>
<td>Services at a high-level:</td>
</tr>
<tr>
<td>Registered Nurse Visits</td>
<td>Registered Nurse Visits</td>
</tr>
<tr>
<td>Wound care</td>
<td>Wound care</td>
</tr>
<tr>
<td>IV Therapy and associated drugs</td>
<td>IV Therapy and associated drugs</td>
</tr>
<tr>
<td>Palliative Care</td>
<td>Palliative Care</td>
</tr>
</tbody>
</table>

**Home Medical Services Benefit**
- Physician assessment and referral required
- SHB BHeC approved providers and fee schedule.

<table>
<thead>
<tr>
<th>HIP</th>
<th>FutureCare Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered at 100%</td>
<td>Covered at 100%</td>
</tr>
<tr>
<td>Benefit excludes Urology</td>
<td>Benefit excludes Urology</td>
</tr>
</tbody>
</table>

**Kidney Transplant**

<table>
<thead>
<tr>
<th>HIP</th>
<th>FutureCare Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>$100,000 lifetime max</td>
<td>$100,000 lifetime max</td>
</tr>
</tbody>
</table>

**Dialysis**
- At SHB BHeC approved facilities

<table>
<thead>
<tr>
<th>HIP</th>
<th>FutureCare Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered at 100%</td>
<td>Covered at 100%</td>
</tr>
</tbody>
</table>

**Anti-rejection Drugs**

<table>
<thead>
<tr>
<th>HIP</th>
<th>FutureCare Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered at 100%</td>
<td>Covered at 100%</td>
</tr>
</tbody>
</table>

**HID Supplemental Benefits**

<table>
<thead>
<tr>
<th>HIP</th>
<th>FutureCare Plans</th>
</tr>
</thead>
</table>

**GP Office Visits**

<table>
<thead>
<tr>
<th>HIP</th>
<th>FutureCare Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>$42 per visit - max 4 visits per year</td>
<td>$46 per visit</td>
</tr>
</tbody>
</table>

**Specialist Physician Visits**

<table>
<thead>
<tr>
<th>HIP</th>
<th>FutureCare Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>$170 for two initial consults max/year</td>
<td>$170 for two initial consults max/year</td>
</tr>
<tr>
<td>$75 for three follow up visits max/year</td>
<td>$75 for three follow up visits max/year</td>
</tr>
<tr>
<td>E.g. Includes oncology physician services at Bermuda Cancer and Health</td>
<td>E.g. Includes oncology physician services at Bermuda Cancer and Health</td>
</tr>
</tbody>
</table>

**Wellness Benefit**

<table>
<thead>
<tr>
<th>HIP</th>
<th>FutureCare Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% coverage per visit/session to a max of $35 per visit, up to 6 visits per year</td>
<td>80% coverage per visit/session to a max of $35 per visit, up to 6 visits per year</td>
</tr>
<tr>
<td>E.g. Asthma, nutrition, diabetes, lifestyle counseling, fall prevention and counseling for smoking cessation</td>
<td>E.g. Asthma, nutrition, diabetes, lifestyle counseling, fall prevention and counseling for smoking cessation</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>HIP</td>
</tr>
<tr>
<td>------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Personal Home Care services:**

- Requires Prior Approval
- Policyholder must have continuous active policy for 12 months prior to being eligible for this benefit

**Radiation Treatments for Cancer Care**

- Local - Covered at 100%
- Overseas
  - HID preferred network – covered at 60%
  - Non-HID preferred network – covered at 50%

**Vision Benefit**

- Applicable either in Bermuda or Overseas
- Eye examination and prescribed eyewear – not covered.

**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
Overseas Treatment

- Referrals will be required with the exception if travelling abroad 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.

<table>
<thead>
<tr>
<th>HIP</th>
<th>FutureCare Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>60% coverage at HID preferred facility</td>
<td>75% coverage at HID preferred facility</td>
</tr>
<tr>
<td>50% coverage at a non-HID preferred facility</td>
<td>65% coverage at a non-HID preferred facility</td>
</tr>
<tr>
<td>o If travelling abroad, only emergency treatment covered</td>
<td>o If travelling abroad, only emergency treatment covered</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>
</table>
| 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

<table>
<thead>
<tr>
<th>Plans</th>
<th>Eligibility</th>
<th>Monthly Premiums</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Persons under 65 or eligible for subsidized premiums*</td>
<td>Persons over 65 not 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>For persons between 0–18 years old OR up to 21 years old if registered full time in a local educational facility.</td>
<td>$190</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.

**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>Cardiology</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>Orthopedics</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>Oncology</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>
</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. 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.

<table>
<thead>
<tr>
<th>Thomas Jefferson University Hospital</th>
<th>Philadelphia, PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nephrology</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>Kidney Transplant</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>Paediatrics</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>Trauma</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>General</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>Toronto General Hospital / Toronto Western Hospital</td>
<td>Toronto, ON</td>
</tr>
<tr>
<td>Good Samaritan Medical Center</td>
<td>West Palm Beach, FL</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>
</tbody>
</table>

**United Kingdom**

| Bupa Cromwell Hospital               |                  |
| King's College Hospital              |                  |
| Royal Brompton & Harefield          |                  |
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
**FORM-CA12 – Group Accounts Enrolment Form**

![Form Image](image-url)

**Section A: Employer’s Information**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Group</td>
<td></td>
</tr>
<tr>
<td>Mailing Address</td>
<td></td>
</tr>
<tr>
<td>Parish</td>
<td></td>
</tr>
<tr>
<td>Postal Code</td>
<td></td>
</tr>
<tr>
<td>Number of Employees and Non-Employed Spouses</td>
<td></td>
</tr>
<tr>
<td>Group Effective Date (dd/mm/yy)</td>
<td></td>
</tr>
<tr>
<td>1st Premium Due</td>
<td></td>
</tr>
<tr>
<td>Primary Contact Person</td>
<td></td>
</tr>
<tr>
<td>Phone #</td>
<td></td>
</tr>
<tr>
<td>Alternate Phone #</td>
<td></td>
</tr>
<tr>
<td>Email Address</td>
<td></td>
</tr>
<tr>
<td>Name of Previous Insurer</td>
<td></td>
</tr>
<tr>
<td>Effective Date (dd/mm/yy)</td>
<td></td>
</tr>
<tr>
<td>Termination Date (dd/mm/yy)</td>
<td></td>
</tr>
</tbody>
</table>

**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): __/__/____
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-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.

Mailing Address: Health Insurance Department, P.O. Box HM 2166, 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.gov.bm Email: hip@gov.bm
Form CA14 – Compulsory Application

Health Insurance Department
Compulsory Application for Enrolment

Plan Type: ☐ FutureCare ☐ HIP
☐ New Customer ☐ Re-enrolment*

FOR OFFICIAL USE
Policy Number: ____________________________
Effective Date (dd/mmy): ____________________
Enrolment AR Number (if reinstatement): ________________
Approved By and Date (dd/mmy): __________

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 2180, Hamilton HM 1JX
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
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: ____________________________________________
*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 dependant is 19 to 21 years of age, the dependant 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): _______ / _______ / _______
Health Insurance Department
Application for a Certificate of Entitlement
(for persons 65 years of age or older)

Applicant Details (Please Print)

Name: [Patient's Name]
(Mr./Mrs./Miss./Ms.) [First Name] [Middle Name] [Last Name]

Mailing Address: [Mailing Address]

Parish: [Parish]
Postal Code: 

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

Email Address: 

Eligibility Details

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

Present Employer (if any): 

Please answer ALL questions as they apply to you:

Check One
Yes
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.

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

MANAGER CHECK ONLY

Date Reviewed (dd/mm/yy): [Date]
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 12
Street Address: Sofia House, 2nd Floor, 48 Church Street, Hamilton HM 12

FORM-CA02 – Policy Cancellation / Plan Transfer Form

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): ___/___/___

(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

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 IX
Street Address: Sofia House, 2nd Floor, 46 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

* 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 1XJ
Street Address: Sofia House, 2nd Floor, 46 Church Street, Hamilton HM 12
Phone: 441-299-5210  Fax: 441-299-5213  Website: www.hip.gov.bm  Email: hip@go.gov.bm

FORM CA05 – Policyholder Information Change Request V05.00
34 March 2014
FORM-CA16 – Direct Debit Individual Form

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.**

<table>
<thead>
<tr>
<th>Name on Bank Account to be Debit:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bank Name (Bermuda Banks Only):</td>
<td></td>
</tr>
<tr>
<td>Bank Account Number (Bermuda Banks Only):</td>
<td></td>
</tr>
<tr>
<td>(For accuracy, proof of account name and number portion of bank statement must be attached to this form)</td>
<td></td>
</tr>
<tr>
<td>Account Type (Chequing or Savings):</td>
<td></td>
</tr>
<tr>
<td>Currency Type: Bermuda Dollars Only</td>
<td></td>
</tr>
</tbody>
</table>

**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.

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

MKT-CA10 HIP and FC Guide Page 23 of 26
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).
# 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):*

<table>
<thead>
<tr>
<th>Name of Group:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mailing Address:</td>
<td></td>
</tr>
<tr>
<td>Parish:</td>
<td></td>
</tr>
<tr>
<td>Postal Code:</td>
<td></td>
</tr>
<tr>
<td>Primary Contact Person:</td>
<td></td>
</tr>
<tr>
<td>Telephone Number:</td>
<td></td>
</tr>
<tr>
<td>Email Address:</td>
<td></td>
</tr>
<tr>
<td>Group Number:</td>
<td></td>
</tr>
</tbody>
</table>

- [ ] New Request for Direct Debit
- [ ] Change to Existing Direct Debit Record
- [ ] Cancellation

*All fields are mandatory

### Employer Bank Details *(Payer):*

- **Name on Bank Account to be Debitied:**

- **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.

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Mailing Address: Health Insurance Department, P.O. Box 2160, Hamilton HM JX
Street Address: Sofia House, 2nd Floor, 48 Church Street, Hamilton HM 12
Phone: 441-295-8210 Fax: 441-295-8213 Website: [www.gov.bm](http://www.gov.bm) Email: [hip@gov.bm](mailto:hip@gov.bm)
For Office Use:
The first debt 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).

Print Name:
Position:
[If Required]

Signature 1:

Date (dd/mm/yyyy):

Company Name:

Signature 2:

Date (dd/mm/yyyy):

[Image]

Acknowledgement:

By signing the Monthly Premium Payment Direct Debit Request form, I 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 debt is scheduled until this authorization is revoked.

Date (dd/mm/yyyy):

[Image]

5. In order to cancel this agreement, H.I.D. 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 H.I.D. or changes to their bank account information by the 15th day of the month.

7. Changes to the monthly premium amount(s) are subject to approval by your request or by H.I.D. or the Group's policy. Any changes to the insurance coverage will be reflected on the Employer’s records. The new amount will be debited from the Employer’s account at the effective date of the change.

8. If the Group’s policy is terminated, either by your request or by H.I.D., the Group’s policy will be terminated. The Employee will need to apply for Direct Debit in accordance with the Employer’s policy or H.I.D. The Employee will remain liable for any amounts outstanding on the date the policy is terminated.

9. I.D. 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.