Health Insurance Department
Voluntary
Application for Enrolment

Plan Type: ☐ FutureCare ☐ HIP

☐ New Customer ☐ Re-Enrolment*

FOR OFFICIAL USE

Policy Number: _____

Effective Date (d/m/y): _____

Existing AR Number if Re-Enrolment:

_____

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

Applicant Details (Please Print)

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

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

Mailing Address:

Parish: Postal Code:

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

Email Address: _____

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

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

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

If yes, list lapse Start and End Dates: _____

Verification of Benefits Letter (please check one): ☐ Mailed to the address above, or ☐ Collected in person at HID

If the letter is to be collected in person at HID, please allow two business days to complete.

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 2160, Hamilton HM JX
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