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.

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).