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: _____

Existing 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

Group Effective Date (d/m/y): ☐☐ / ☐☐ / ☐☐

Group Name:

Mailing Address:

Parish: **Postal Code:**

Contact Name:

Primary Phone #: ☐☐☐ - ☐☐☐☐ **Alternate Phone #:** ☐☐☐ - ☐☐☐☐

E-mail:

# of Employees & Non-employed Spouses _____ **1st Premium Due:** _____

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

***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.
  - **Cheques should be made payable to the Health Insurance Fund**
- 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.

In accordance with the provisions and exclusions under Parts 1 and 2 of the Personal Information Protection Act (PIPA), the Health Insurance Department is committed to ensure that all information given on this Form will be held in the strictest confidence and may only be released to relevant authorities for such purposes as outlined under the Act. Any insured's health information will be shared between the Health Insurance Department, and any healthcare providers or facilities for the purposes determining healthcare needs, benefits and reimbursement of claims.

I, _____(Employer's Name) declare that the information above is accurate to the best of my knowledge.

Employer's Signature: _____ 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.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):**_____
Employee UPI:_____
Spouse UPI: _____

Group Name:

Group Number:

Section B: Employee Information

Name: ☐ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. **Health Plan**: ☐ FutureCare ☐ HIP **Hiring Date (d/m/y)**: / /

First **Last:**

Middle Name: **Date of Birth (d/m/y):** / /

Mailing Address:

Parish **Postal Code:**

Social Insurance Number: **Telephone Number:** -

E-mail Address: _____

Gender: ☐ Male ☐ Female **Marital Status**: ☐ Single ☐ Married **Occupation**: _____

Prior Employer: _____ **End Date (d/m/y):** / /

Prior Insurer: _____ **Policy End Date (d/m/y):** / /

Section C: Non-Employed Spouse of Employee

Name: ☐ Mr. ☐ Mrs. **Health Plan**: ☐ FutureCare ☐ HIP **Effective Date**: / /

First **Last:**

Middle Name: **Date of Birth (d/m/y):** / /

Address (If different from above**):**

Parish **Postal Code:**

Social Insurance Number: **Telephone Number:** -

E-mail Address: _____

***Please make copies of this page for additional employees**

In accordance with the provisions and exclusions under Parts 1 and 2 of the Personal Information Protection Act (PIPA), the Health Insurance Department is committed to ensure that all information given on this Form will be held in the strictest confidence and may only be released to relevant authorities for such purposes as outlined under the Act. I declare that the information above is accurate to the best of my knowledge. Any insured's health information will be shared between the Health Insurance Department, and any healthcare providers or facilities for the purposes determining healthcare needs, benefits and reimbursement of claims.

Employee Signature: _____ Date (dd/mm/yy): / /