

	Hea Co A Plan	Policy Number: Effective Date (d/m/y): Existing AR Number if Re-enrolling:													
TATE RUNT	Approved By and Date (d/m/y):														
Applicant Details	(Please Prin	nt)					opioved i	Jy and D	ate (u	,,,,,,,				_	
Name:															
(Mr./Mrs	/Miss/Ms.)	(First Nan	ne)											1	
(Middle I	Name)				(Last N	Name)								7
Mailing Address:															
Parish:						F	Postal Code:								
Date of Birth (dd/m	nm/yy):		/		Tele	ephor	e Nu	mber:	:						
Email Address:												 			
Social Insurance N	lumber:		Cer	tificate	of Entitler	ment	# (if a	pplica	able	e):					
Are you a resident	of Bermuda?	Yes □] No												
Verification of Be f the letter is to be c									r 🗀] Col	lecte	d in pe	rson at	t HID	
Please note: For	Re-enrolmer	nts, a discus	sion with	a Custo	mer Serv	vice F	Repres	senta	tive	is re	quire	ed.			
_apsed period: Fro	om Date (dd/r	nm/yy):	/	/		To Da	ate: (d	dd/mn	n/yy	/):		/			
Employment															
Name or Business	Name:														
Address:															
Telephone Numbe	r:]-		Od	ccupation	ı:									
Employment Start	Date (dd/mm	/yy):		/											
nsurance Declar	ation														
Previous Insurer:															
Date Started (dd/m	nm/yy):		/	Date	e Expired	(dd/r	nm/yy	/):]/[/			
Have you had HIP		e Insurance	e before?		•		- •								
declare that the in	nformation ab	ove is accu	rate to the	e best o	f my kno	wledg	e.								
Signed:				Da	ate (dd/m	ım/yy): [1		1				
-				_	,					_	-				

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.