Health Insurance Department
Health Insurance Plan - Youth Application Form

FOR OFFICIAL USE

Approved By and Date **(DD/MM/YY):**

_____

Processed by CSR and Date **(DD/MM/YY)**:

_____

No. of Members: _____

Existing Group #: _____

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*)

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

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 dependent is 19 to 21 years of age, the dependent 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): / /

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