BF&M

Application for Conversion – Individual Health Policy

Complete this application to convert an existing Group Health Policy into an Individual Health Policy.
Eligibility for conversion must be within 30 days following termination from Group plan and only if employee has been employed for 2 complete years.

1. Group policy information

Name of previous employer:	
Group number:	Certificate number:
Employment termination date (dd-mmm-yyyy):	Group coverage termination date (dd-mmm-yyyy):

2. Policy owner / Primary insured information

Name (First/Middle/Last):	Gender: Male Female
DOB (dd-mmm-yyyy):	Place of birth (city and country):
Nationality (list all):	
Residential address:	
Mailing address (if different):	
Phone: H W C	Email:
Occupation and nature of business:	
Length of continuous employment with employer:	

3. Dependent information

Dependent name (First/Middle/Last)	DOB (dd-mmm-yyyy)	Gender	Relationship to insured	Nationality	Residential address

4. Health questions

Have you ever been tested, treated, counselled or diagnosed for any of the following: Cancer, heart attack, heart disease, stroke, diabetes, COPD lung disease, organ failure, kidney disease, HIV/AIDS, or neurological disorders?	Yes	No
Have you ever been tested, treated, counselled or diagnosed for any of the following: Asthma, obesity, high blood pressure, diseases of the spine or joints, or inflammatory bowel disorders?	Yes	No
Do you expect to receive medical treatment within the next year? If "yes", please describe:	Yes	No

Policy name:

5. Premium and payment information

The effective date of the policy will be the first day of the month closest to the approval date. The first premium will be applied at that time.

First premium (The application must be accompanied by the non-refundable $75 application fee. First premium must be paid upon approval. Policy will not be activated until first premium received.)	
Premium amount: BMD$	+ $75 (non-refundable application fee) = $
Payment method: Online banking bill payment	Debit/Credit card **(First premium only)**

Authorisation and declaration (to be read and completed by each insured)

By signing this form I confirm/understand that:

- *All statements and answers contained in this application are full, complete, and true. I understand that failure to disclose information, or providing incorrect information, may constitute misrepresentation or fraud and may void the insurance coverage.*
- *This application and the statements and answers in any document or questionnaire completed in connection with this application, shall form the basis of the policy and the interim insurance should any be granted.*
- *All dependents have authorised me to enter into this policy on their behalf and I am the parent or legal guardian of any dependents under the age of 18.*
- *The policy shall not take effect until:*
  - *It has been approved by BF&M*
  - *Any policy changes have been completed and accepted by the Policy Owner*
  - *All premiums have been paid*

Data protection declaration

☐ *I make the following declarations:*

- *I consent to BF&M processing my personal data, including my health and medical data, in accordance with BF&M's Privacy Policy (www.bfm.bm/privacy).*
- *I understand that I may withdraw my consent at any time by email to privacy@bfm.bm but that may impact BF&M's ability to provide insurance or related services or pay insurance claims benefits.*
- *I confirm that any personal data I provide to BF&M in respect of any third party is done with that third party's consent and knowledge of BF&M's processing of their personal data.*

I submit this application and understand that by checking the "ACCEPT TERMS" box below, I confirm that I agree with the authorisation and declaration set out above.

☐ **ACCEPT TERMS**

Signature of Policy owner/Primary insured (on behalf of themselves and any dependents):	Date (dd-mmm-yyyy):

BF&M Representative's name (printed):	
Sign:	Date (dd-mmm-yyyy):