Group Insurance Enrolment Form

FOR BF&M OFFICIAL USE

CERT No. _____ ENTRY No. _____

CLASS/CATEGORY _____ PROCESS DATE _____

COMMENCEMENT DATE _____ HEALTH STATEMENT ◯ DENTAL STATEMENT ◯ _____

COMPLETE FOR EMPLOYEE HEALTH COVERAGE (PLEASE PRINT)

GROUP POLICY NAME	GROUP POLICY NUMBER

EMPLOYEE NAME			DATE OF BIRTH		
LAST	FIRST	MIDDLE	DAY	MONTH	YEAR

GENDER	OCCUPATION	ADDRESS
MALE ◯ FEMALE ◯		

TELEPHONE NUMBER	EMAIL ADDRESS

HOURS WORKING PER MONTH (MUST WORK A MIN. OF 45HRS/MONTH)	EFFECTIVE DATE OF EMPLOYMENT

PLEASE TICK ONE OF THE FOLLOWING, IF APPLICABLE	CURRENTLY INSURED
DIRECTOR ◯ OWNER ◯ PARTIAL OWNER ◯ N/A ◯	YES ◯ NO ◯

SUPPLEMENTAL INSURANCE CARRIER	EFFECTIVE DATE	TERMINATION DATE

PREVIOUS INSURANCE CARRIER	EFFECTIVE DATE	TERMINATION DATE

COUNTRY OF CITIZENSHIP	EMPLOYEE AND DEPENDENTS ARE RESIDENT IN BERMUDA FOR AT LEAST 6 MONTHS/YEAR
BERMUDA ◯ OTHER ◯ STATE	YES ◯ NO ◯

List below information of Dependents to be covered (Spouse, Domestic Partner and Children)

NAME			RELATIONSHIP	DATE OF BIRTH		
LAST	FIRST	MIDDLE		DAY	MONTH	YEAR
LAST	FIRST	MIDDLE		DAY	MONTH	YEAR
LAST	FIRST	MIDDLE		DAY	MONTH	YEAR
LAST	FIRST	MIDDLE		DAY	MONTH	YEAR

DOES YOUR DEPENDENT(S) HAVE A CURRENT INSURANCE CARRIER	IF YES, PLEASE STATE INSURANCE CARRIER
YES ◯ NO ◯	

EFFECTIVE DATE	TERMINATION DATE, (IF) APPLICABLE	DOES YOUR SPOUSE/DOMESTIC PARTNER MEET ELIGIBILITY CRITERIA
		YES ◯ NO ◯

IF SPOUSE/DOMESTIC PARTNER IS TO BE ENROLLED PLEASE TICK EMPLOYMENT STATUS:	PLEASE SELECT LEVEL OF COVERAGE FOR YOUR SPOUSE/DOMESTIC PARTNER
UNEMPLOYED ◯ *EMPLOYED ◯ SELF-EMPLOYED ◯	FULL COVERAGE ◯ SUPPLEMENTAL COVERAGE ◯

*Employed Spouse/Domestic Partner must have the Basic Benefit (Standard Hospital Benefit) with his/her employer.
Spouse must not be legally divorced, must live in the same household, and must not be eligible for coverage as an insured. Domestic Partner must be living with employee on a continuous basis in a conjugal relationship, if not legally married for 12 months prior to application for coverage and must be publically represented as employee's partner.

DOES YOUR DEPENDENT CHILD(REN) MEET ELIGIBILITY CRITERIA?

YES ◯ NO ◯

Dependents eligible are Children, Stepchildren and Legally Adopted Children. Children must be unmarried and rely on primary insured for principle support and maintenance. Documentation submitted for Handicapped Children, which substantiates uninterrupted continuance of incapacity and that child is dependent on Insured for more than 50% of support and maintenance. Proof of full time enrolment in school if over Bermuda School leaving age submitted in the form of a receipt.

School Information

NAME OF CHILD	NAME OF SCHOOL, COLLEGE OR UNIVERSITY	LOCATION

IS SCHOOL RECEIPT SUBMITTED?

YES ◯ NO ◯ N/A ◯

INSURANCE PLANS - PLEASE TICK THE APPROPRIATE INSURANCE PLAN(S)

STANDARD HOSPITAL BENEFIT (SHB) ☐ GLOBAL HEALTH ☐ GLOBAL PLUS ☐ GLOBAL ELITE ☐ BASIC DENTAL ☐ COMPREHENSIVE DENTAL ☐ ORTHODONTIC ☐
SELECT HEALTH ☐ PRIVATE WARD ☐ SEMI PRIVATE WARD ☐ LIFE ☐ AD&D ☐ LTD ☐ WI ☐

PLEASE NOTE THE FOLLOWING RESTRICTIONS ON ALL HEALTH PLANS:
- You must remain in the chosen plan for a minimum of two years.
- You may switch up or down one level only without medical underwriting on the policy anniversary date following the completion of the two year period.
- You will have 31 days prior to your policy anniversary date to notify BF&M that you would like to switch to another level.

EMPLOYER'S SIGNATURE	EMPLOYEE'S SIGNATURE

PRINT NAME	DATE			PRINT NAME	DATE		
	DAY	MONTH	YEAR		DAY	MONTH	YEAR

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