

CAYMAN ISLANDS



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**THE HEALTH INSURANCE LAW
(2011 REVISION)**

THE HEALTH INSURANCE (AMENDMENT) REGULATIONS, 2012

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CAYMAN ISLANDS

**THE HEALTH INSURANCE LAW
(2011 REVISION)**

THE HEALTH INSURANCE (AMENDMENT) REGULATIONS, 2012

In exercise of the powers conferred by section 25 of the Health Insurance Law (2011 Revision), the Governor in Cabinet makes the following Regulations -

1. (1) These Regulations may be cited as the Health Insurance (Amendment) Regulations, 2012. Citation and commencement
- (2) These Regulations shall come into force as follows -
 - (a) regulations 2(b), 3(b), 4, 5, 8, 9, 10, 18 and 19 shall come into force immediately after section 6 of the Health Insurance (Amendment) Law, 2010 comes into force; and
 - (b) the other regulations shall come into force on the date on which these Regulations are published in the Gazette.
2. The Health Insurance Regulations (2005 Revision), in these Regulations referred to as the “principal Regulations”, are amended in regulation 2 as follows - Amendment of regulation 2 of the Health Insurance Regulations (2005 Revision) - definitions
 - (a) in subregulation (1) -
 - (i) by deleting the definition of the word “ambulant surgery”;
 - (ii) by inserting before the definition of the word “Commission” the following definition -

“ “ambulant service ” means service that is performed in a facility approved under the Health Practice Law (2005 Revision) on a patient who enters and leaves the facility after recovery, within twenty-four hours and includes outpatient radiation, chemotherapy and surgical services and procedures conducted in an ambulant facility;”; and
 - (iii) by deleting the definition of the word “dependant”; and
 - (b) in subregulation (2) by deleting the words “Standard Contracts” and substituting the words “Standard Health Insurance Contract”.
3. The principal Regulations are amended in regulation 3 as follows - Amendment of regulation 3 - prescribed health care benefits

- (a) in subregulation (1) by inserting after the words “prescribed health” the word “care”; and
- (b) by repealing subregulation (2) and substituting the following subregulations -

“ (2) An employer shall offer to his employees insurance coverage no less than the standard health insurance contract as set out in the First Schedule.

(2A) An application for the issue of the standard health insurance contract shall be made to an approved insurer in the form set out in the Fourth Schedule and the approved insurer shall, within ten working days of receipt of the application, advise the applicant and his employer, if any, whether the standard health insurance contract will be issued.”.

Repeal and substitution of regulation 4 - insurance for high risk insurance persons

4. The principal Regulations are amended by repealing regulation 4 and substituting the following regulation -

“Insurance for high risk insurance persons

4. (1) Where a person applies to an approved insurer to obtain insurance under the standard health insurance contract for a high risk insurance person, the approved insurer shall -

- (a) provide insurance cover under the standard health insurance contract at the standard premium; or
- (b) subject to the following provisions of this regulation, provide insurance cover under the standard health insurance contract -
 - (i) at an increased premium that does not exceed two hundred percent of the standard premium, to take into account the increased risk being assumed by the approved insurer; or
 - (ii) at an increased premium that exceeds two hundred percent of the standard premium, to take into account the increased risk being assumed by the approved insurer.

(2) Where, after consideration of an application for the issue of the standard health insurance contract for a high risk insurance person, an approved insurer decides to provide insurance cover for the high risk insurance person under the

standard health insurance contract at an increased premium that does not exceed two hundred percent of the standard premium, the approved insurer shall, within fifteen days of making the decision, notify the Commission of the decision and provide the Commission with such documents and information as the Commission considers necessary, including an actuarial assessment.

(3) Where, after consideration of an application for the issue of the standard health insurance contract for a high risk insurance person, an approved insurer decides to provide cover for the high risk insurance person under the standard health insurance contract at an increased premium that exceeds two hundred percent of the standard premium, the approved insurer shall, within fifteen days of making the decision, apply to the Commission for approval of the decision and provide the Commission with such documents and information as the Commission considers necessary, including an actuarial assessment.

(4) Where the Commission is of the view that a decision made by an approved insurer pursuant to subregulation (2) or (3), is unreasonable, the Commission shall, within fifteen days of receipt of the decision, order such variation of the decision as the Commission considers appropriate and the approved insurer shall give effect to the decision as varied.

(5) An order made by the Commission under subregulation (4) shall take effect on the tenth day after the date on which the order was made.

(6) A person aggrieved by an order of the Commission under subregulation (4) may, within ten days of the date on which the order was made, appeal to the Grand Court in accordance with rules made by the Rules Committee for the purposes of this regulation.

(7) On an appeal under subregulation (6), the Grand Court may confirm or discharge the order of the Commission.

(8) Whoever fails to provide information or

documents under subregulation (2) or (3) is guilty of an offence and liable on summary conviction to a fine of ten thousand dollars.”.

Insertion of regulation
4A - insurance for
uninsurable persons

5. The principal Regulations are amended by inserting after regulation 4 the following regulation -

“Insurance
uninsurable
persons

for

4A. (1) Where, after consideration of an application for the issue of the standard health insurance contract, an approved insurer decides to deem a person unacceptable for cover under the standard health insurance contract, the approved insurer shall, within fifteen days of making the decision, apply to the Commission for approval of the decision and provide the Commission with such documents and information as the Commission considers necessary, including an actuarial assessment..

(2) Where the Commission is of the view that a decision made by an approved insurer pursuant to subregulation (1), is unreasonable, the Commission shall, within fifteen days of receipt of the decision, order such variation of the decision as the Commission considers appropriate and the approved insurer shall give effect to the decision as varied.

(3) An order made by the Commission under subregulation (2) shall take effect on the tenth day after the date on which the order was made.

(4) A person aggrieved by an order of the Commission under subregulation (2) may, within ten days of the date on which the order was made, appeal to the Grand Court in accordance with rules made by the Rules Committee for the purposes of this regulation.

(5) On an appeal under subregulation (4), the Grand Court may confirm or discharge the order of the Commission.

(6) Whoever fails to provide information or documents under subregulation (1) is guilty of an offence and liable on summary conviction to a fine of ten thousand dollars.”.

6. The principal Regulations are amended in regulation 5 by repealing subregulation (1) and substituting the following subregulation - Amendment of regulation 5 - health care for indigent persons

“ (1) The Commission on behalf of the Government shall, in order to cover medical costs for indigent persons, collect from-

- (a) each approved insurer, ten dollars per month of each premium charged by the approved insurer under each standard health insurance contract effected by such insurer in respect of an insured person with no dependants; and
- (b) each approved insurer, twenty dollars per month of each premium charged by the approved insurer under each standard health insurance contract effected by such insurer in respect of an insured person with dependants.”.

7. The principal Regulations are amended in regulation 6 as follows - Amendment of regulation 6 - premiums

- (a) in subregulation (3)(b) by inserting after the word “adjustment” the words “(to be effected within fifteen working days)”; and
- (b) in subregulation (8) by deleting the words “sections 5 and 6” and substituting the words “sections 7 and 8 of the Law”.

8. The principal Regulations are amended by repealing regulation 7 and substituting the following regulation - Repeal and substitution of regulation 7 - cover

“Cover

7. (1) Subject to these Regulations, the minimum period of cover provided under any standard health insurance contract shall be three months or the period for which premiums have been paid, whichever is less.

(2) Where a premium is paid by the employer in respect of any insured person, that insured person and his dependants, if any, shall be covered under the standard health insurance contract for the month for which the premium is paid notwithstanding that, during the course of that month, the insured person’s employment may be terminated or he otherwise ceases to be compulsorily insured.

(3) Where an insured person takes up employment in the course of a month the effective day for the purpose of determining liability of his employer under section 5 of the Law shall be the first day of employment, except that, where the insured person is already insured for the month in which the employment begins under a contract of insurance effected by his previous employer, the effective day shall be the first

day of the month next following the first day of employment.

(4) Cover under a standard health insurance contract ceases on the first day of the month next following the date of the termination of employment except that, in accordance with section 15 of the Law, if the insured person does not become insured under any other employer, cover under the contract shall continue to be made available for a period of three months from the date of termination of employment or until he becomes employed, whichever is earlier.

(5) This regulation shall apply with the necessary changes in respect of the dependants of the insured person.

(6) Where an insured person changes his approved insurer and, prior to that change, the insured person had been insured continuously for a period of not less than one year under one or more other health insurance contracts effected by an approved insurer, with breaks in insurance cover not exceeding three months in the aggregate, then -

- (a) the new approved insurer for the insured person shall provide health insurance cover to the insured person and his dependants -
 - (i) under a plan of benefits which is favourably comparable to the plan of benefits provided by the previous approved insurer; or
 - (ii) where there is no favourably comparable plan of benefits, under a plan of benefits which is offered by the new approved insurer for the insured person and which is as similar as possible to the supplemental plan of benefits provided by the previous approved insurer;
- (b) the insurance cover so provided to the insured person and his dependants shall not contain, with respect to the medical condition of the insured person or his dependants, any exclusions or limitations of cover that were not specified by the previous approved insurer;
- (c) the insurance cover so provided to the

insured person and his dependants may be provided at an increased premium; and

- (d) for the purpose of applying any pre-existing condition requirements for the insurance cover, the insurance cover of the insured person and his dependants shall be deemed to have begun on the date that it was deemed to have begun under the respective previous health insurance contracts effected by the previous approved insurer.

(7) Where an employer changes his approved insurer -

- (a) the new approved insurer shall not refuse to provide insurance cover to any employee insured under the previous health insurance contract effected by the previous approved insurer;
- (b) the insurance cover so provided to the employee shall not contain, with respect to the medical condition of the employee, any exclusions or limitations of cover that were not specified by the previous approved insurer;
- (c) the insurance cover so provided to the employee may be provided at an increased premium; and
- (d) for the purpose of applying any pre-existing condition requirements for the insurance cover, the employee's coverage shall be deemed to have begun on the date that it was deemed to have begun under the previous health insurance contract effected by the previous approved insurer.

(8) An approved insurer shall not refuse to renew a contract of insurance on the ground that a compulsorily insured person has contracted an illness.

(9) In this regulation -

“pre-existing condition”, in relation to an employee or insured person, means a medical condition known to the employee or insured person prior to the date of a health

insurance contract or a medical condition for which treatment was given or recommended or drugs taken or prescribed or of which symptoms were or had been manifest during the period of twelve months prior to the date of the health insurance contract and of which the insured person should have been aware.”.

Amendment of regulation 9 - payment of claims

9. The principal Regulations are amended in regulation 9 by repealing subregulation (2) and substituting the following subregulations -

“ (2) The claim forms to be used by a registered medical practitioner, a health care facility and an approved insurer shall be a HCFA 1500 or UB 92 form and shall include CPT codes and ICD codes and such other approved diagnosis and treatment codes as may be applicable.

(2A) All new CPT codes which are introduced and published from time to time by the American Medical Association (CPT Code Book Professional Edition) due to changes in procedures, treatments, services, technology or other reasons shall be accepted and utilized, for claims processing, by registered medical practitioners, health care facilities and approved insurers.

(2B) Registered medical practitioners and health care facilities shall file the new codes as an Individual Report with the Commission, and the fee for a new code shall be determined and communicated to the relevant medical practitioner, health care facility and approved insurer within sixty days of filing and the new CPT code and fee shall be published in accordance with the Law.”.

Repeal and substitution of regulation 10 - maximum benefits

10. The principal Regulations are amended by repealing regulation 10 and substituting the following regulation -

“Maximum benefits First Schedule

10. Under the Standard Health Insurance Contract set out in the First Schedule, an approved insurer shall be liable to pay on behalf of each compulsorily insured person -

- (a) during each calendar year, not more than \$100,000 in medical fees; and
- (b) during the life of an insured, not more than \$1,000,000 in medical fees.”.

Amendment of regulation 11 - renewal of contract

11. The principal Regulations are amended in regulation 11(2) by deleting the words “with section 12” and substituting the words “with section 15 of the Law”.

12. The principal Regulations are amended in the marginal note to regulation 14 by deleting the word “Authority” and substituting the word “Commission”.
- Amendment of regulation 14 - documents to be submitted to the Authority
13. The principal Regulations are amended in regulation 19 as follows -
- Amendment of regulation 19 - offences
- (a) in subregulation (1) by deleting the words “two hundred and fifty dollars” and substituting the words “five hundred dollars”; and
 - (b) by inserting after subregulation (1) the following subregulation -
“ (1A) Whoever fails to comply with regulation 13 or 14 is guilty of an offence and liable on summary conviction to a fine of ten thousand dollars and if the offence is a continuing one to a fine of five hundred dollars for every day or part of a day during which the offence has continued.”.
14. The principal Regulations are amended in regulation 21 as follows -
- Amendment of regulation 21 - Government employees
- (a) in subregulation (1) -
 - (i) by inserting the word “and” at the end of sub-subregulation (b); and
 - (ii) by repealing sub-subregulation (c); and
 - (b) in subregulation (2) by deleting the words “under section 3(3)” and substituting the words “under section 5(3) of the Law”.
15. The principal Regulations are amended in regulation 22(1) by deleting the words “in regulation 20(1)” and substituting the words “in regulation 21(1)”.
- Amendment of regulation 22 - seamen and veterans
16. The principal Regulations are amended in regulation 23(3) by deleting the words “under section 18” and substituting the words “under section 23 of the Law”.
- Amendment of regulation 23 - determination of disputes
17. The principal Regulations are amended -
- Amendment of principal Regulations - general substitution of the words “approved insurer” for the words “approved provider”
- (a) by deleting the words “approved provider” wherever they appear and substituting the words “approved insurer”; and
 - (b) in regulation 5(1) by deleting the words “such provider” wherever they appear and substituting the words “such insurer”.
18. The principal Regulations are amended by repealing the First Schedule and substituting the following Schedule -
- Repeal and substitution of First Schedule - prescribed health care benefits

“FIRST SCHEDULE

(Regulation 3)

PRESCRIBED HEALTH CARE BENEFITS

Part 1

Standard Health Insurance Contract

COVERAGE LEVELS IN CI\$

Individual Lifetime Maximum	\$1,000,000
Individual Annual Maximum	\$100,000
<u>In-patient Benefits:</u>	
Coinsurance Individual Maximum (applies to hospitalization, surgery, chemotherapy and radiation therapy only)	20% of the first \$5,000 of eligible charges up to \$1,000 per annum
In-patient Hospital (including physician, surgical, room and board and ancillary expenses) Out-patient Surgery in an ambulatory surgical centre or hospital Chemotherapy or Radiation Therapy (in-patient or out-patient) Maternity-labour and delivery, major maternity procedures and hospitalization Post-Natal (Newborn Care)	80% to coinsurance maximum, then 100% to Individual Annual Maximum (\$100,000)
In-patient Benefits - Mental Health	80% to coinsurance maximum, then 100% up to \$25,000 per lifetime
<u>Out-patient Benefits:</u>	
Doctor Office Visits and other	80% within the annual \$400 out-patient

<p>physician fees including office procedures</p> <p>Diagnostics including radiology/laboratory</p> <p>Physiotherapy with physician referral only</p> <p>Prescription Drugs including contraceptives and contraceptive devices available by prescription only</p> <p><u>Wellness Benefits:</u></p> <p>Routine Physicals, Annual Exams, Wellness Services</p> <p>Well Child Care</p> <p>Nutrition counselling with physician referral only</p> <p>One Dental examination/check-up and prophylaxis annually</p> <p><u>Maternity Benefits:</u></p> <p>Antenatal (pre-natal)</p>	<p>benefit</p> <p>80% within the annual \$200 wellness services</p> <p>80% within the \$500 per pregnancy benefit</p>
<p><u>Emergency Medical Services</u> (Including medication, drugs, ground ambulance for “threat to life or limb”, sudden onset conditions)</p>	<p>100% of the first \$4,000 out-patient services then as per applicable benefit category</p>
<p><u>Haemodialysis</u></p>	<p>100% up to Individual Annual Maximum</p>
<p><u>Air Ambulance</u> Air Ambulance for “life or limb” threatening emergency Medical Airfare for “life or limb”</p>	<p>Based upon medical necessity. 100% up to \$15,000 per annum</p>

threatening emergency	
Repatriation of remains	\$2,000

In-patient Benefits and Ambulant Service Benefits

1. Accommodation and meals up to thirty days in a semi-private room or, where medically necessary, in an intensive care unit.
2. Physicians', specialists' and surgeons' services including ambulant services.
3. Anaesthesia, use of operating room and recovery rooms.
4. Use of all in-patient services of any health care facility.
5. Full nursing service up to thirty days.
6. Standard surgical supplies including oxygen, surgical appliances and implants.
7. Medication and drugs.
8. Use of physiotherapy, inhalation and other rehabilitative therapy facilities.
9. Radiology and Diagnostic Services.
10. Laboratory and pathological studies (including overseas referrals of such studies by registered medical practitioners).
11. Post-natal care for a newly-born dependent child for a period of thirty days from the dependent child's birth to be provided under the mother's benefit until other or alternate coverage is arranged.

Note: Where the Chief Medical Officer/Medical Director and one other registered medical practitioner other than the attending medical practitioner certify that a patient must receive the said benefit for more than thirty days maximum, such patient may claim payment for the cost or part of the cost of the benefit in excess of thirty days.

Part 2

Out-patient benefits

1. Visits to a registered medical practitioner including routine physicals, annual exams, routine laboratory and radiology tests, antenatal services, physiotherapy, prescription drugs, dental check-up and prophylaxis every twelve months, dental surgery for the excision of impacted teeth or a tumour or cyst or treatment for injury to sound natural teeth subject to a limit as prescribed in the plan.
2. Haemodialysis.
3. Emergency medical services, including medication, drugs and ambulance services, subject to a maximum as prescribed in the plan.

Note: In this Part -

“emergency” means a sudden or unexpected occurrence or event causing a threat to life or limb.

Part 3

Benefits which may be excluded under the standard health insurance contract

Benefits will not be provided in connection with -

1. The treatment of any episode of illness or injury which occurred prior to the commencement of the standard health insurance contract, unless the episode of illness or injury or other pre-existing condition was fully disclosed in writing.
2. Consultations in connection with, and treatment for, infertility including in-vitro fertilisation, artificial insemination and other experimental services.
3. Consultations in connection with and treatment for, sexual dysfunction or sex change procedures.
4. Sterilisation.

5. Treatment for any illness caused by or injury sustained in a war (declared or undeclared) or while a person was in active military service in any country.
6. Treatment for injury sustained during hazardous activities, including hang-gliding, sky-diving, parachuting, ballooning, flight in ultra-light aircraft and non-certified scuba diving.
7. Treatment for obesity or weight reduction.
8. Treatment for illness or injury arising from or associated with drug or alcohol abuse, self-inflicted injuries, and sexually transmitted diseases.
9. Treatment for any illness or injury arising from or connected with the Human Immunodeficiency Syndrome.
10. Treatment which, in the opinion of a registered medical practitioner or a health care facility, is not medically necessary.
11. The supply or fitting of eye glasses, contact lenses or hearing aids.
12. Marital counselling, including therapy for marital difficulties and family counselling.
13. Occupational therapy or speech therapy, except where medically necessary.
14. Charges for -
 - (a) rest cures;
 - (b) custodial, hospice or geriatric care;
 - (c) periods of legally enforced quarantine or isolation; or
 - (d) services received in hydros, or nature cure clinics.
15. Home nursing.
16. Services of an intern or resident doctor unless billed by a health care facility.
17. The rental or purchase of orthotic devices or appliances except where those devices or appliances are required to be permanently fastened to an orthopaedic brace.

18. Cosmetic surgery unless deemed medically necessary by two independent registered medical practitioners.
19. Rental or purchase of exercise equipment or similar non-medical equipment and other items for personal comfort.
20. Charges which the insured has no legal obligation to pay or for which no charge would have been made if the insured had no health insurance cover.
21. Treatment, medicine or other supply which is experimental.

In this Part -

“cosmetic surgery” means surgery performed primarily to improve a person’s physical appearance or to restore to normal state through change in the body’s appearance, other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore bodily functions;

“experimental” -

- (a) in relation to treatment, medicine or other supply, means treatment, medicine or other supply which is still a part of a research programme and which has not been approved by the Health Practice Commission established under section 3 of the Health Practice Law; and
- (b) in relation to medicine or other supply, means medicine or other supply which is not included in the British National Formulary or the Physician’s Desk Reference unless it has been approved for use in the Islands by the Chief Medical Officer;

“injury” means any wound, trauma, damage, shock or other physical damage or pain that is inflicted on the body and produced by a sudden physical event such as any violence, fall, collision, laceration, fracture, blow or accident or by an external physical cause, such as burn injury, drowning, poisoning or other toxin;

“medically necessary” in relation to treatment, medicine or other supply, means treatment, medicine or other supply which is-

- (a) appropriate to the diagnosis or treatment of the insured’s illness;
- (b) consistent with accepted medical or professional standards of practice;

- (c) not primarily for the personal comfort or convenience of the insured, his family, his physician or other health provider; and
- (d) the most appropriate level of treatment or medicine that can safely be provided to the insured and which, in the case of in-patient care, cannot be provided safely on an out-patient basis;

“pre-existing condition” means a medical condition known to the compulsorily insured person prior to the date of a health insurance contract or a medical condition for which treatment was given or recommended or drugs taken or prescribed or of which symptoms were or had been manifest during the period of twelve months prior to the date of the health insurance contract and of which the compulsorily insured person should have been aware; and

“semi-private room” means a room in a health care facility that is equipped to accommodate two to four persons.

Part 4

1. The in-patient benefits and ambulant service benefits specified in Part 1 may be provided at a health care facility in the Islands or at an overseas health care facility.
2. The out-patient benefits specified in paragraph 1 of Part 2 shall be limited to out-patient benefits provided in a health care facility in the Islands.
3. Subject to paragraph 5, a compulsorily insured person shall be required to pay, for any benefit in Part 1 received by him at a health care facility or a registered medical practitioner -
 - (a) twenty per cent of the published fee for that benefit where applicable up to an annual maximum of \$1,000 during each calendar year; and
 - (b) any fees which are charged for that benefit and which are in excess of the published fee.
4. An approved insurer shall pay, in respect of each person insured compulsorily with that insurer for any benefit in Part 1 received by that person at a health care facility or registered medical practitioner, eighty per cent of the published fee for that benefit where applicable up to \$4,000 during each calendar year.
5. Notwithstanding paragraphs 3 and 4, an approved insurer shall be liable during each calendar year to pay all fees charged after the first \$5,000

for any benefits to an insured person under Part 1 subject to the annual limit specified in regulation 10.

6. An approved insurer shall be liable to pay eighty per cent of the published fee for the benefits specified under paragraph 1 of Part 2 up to the maximum of the costs for such benefits specified in that paragraph.”.

19. The principal Regulations are amended by inserting after the Third Schedule the following schedule -

Insertion of Fourth
Schedule - Health
Insurance Application
Form

“FOURTH SCHEDULE

(Regulation 3(2A))

**STANDARD HEALTH INSURANCE CONTRACT
HEALTH INSURANCE APPLICATION FORM**

NOTE THE INFORMATION ON THIS FORM IS TREATED AS CONFIDENTIAL

Please check the appropriate boxes:

Individual Coverage Group Coverage

Employed Unemployed Self Employed Retired

Proposed Effective Date of Policy _____

PART A: Applicant Information

	Last	First	Middle	Date of Birth	Sex M/F	Height Feet/Inches	Weight Lbs/Oz	Immigration Status
Applicant								

Postal Address: _____ Email Address: _____

Physical Address: _____

Telephone: _____ Fax: _____

Beneficiary _____ Relationship: _____

Date of Birth _____

Postal Address: _____ Telephone: _____

PART B: Employer Information

Name of Employer: _____ Employer #: _____

Postal Address: _____ Email Address: _____

Physical Address: _____

Telephone: _____ Fax: _____

Employer's signature: _____ Date: _____

PART C: Eligible Dependents

Relationship	Family Members Names Last First Middle	Date of Birth	Sex M/F	Height Feet/Inches	Weight Lbs/Oz	Immigration Status
Spouse						
Child1/ Dependent Offspring						
Child2/ Dependent Offspring						
Child3/ Dependent Offspring						

Is your spouse employed? Y / N. If yes, please provide name of employer: _____

Are medical benefits available from any other approved insurer to any person listed above (Part A &/or Part C)? Y / N. If yes, please provide name of approved insurer and telephone information:

Approved Insurer: _____ Telephone: _____

Has any person listed above (Part A &/or Part C) had continuous coverage for a period of not less than one year? Y/N. If yes, please state the name of the approved insurer: _____

Part D: Medical Questionnaire
Must be completed by all persons

In the last twelve months has any person listed above (Part A &/or Part C) ever been advised to or received medical consultation, care, treatment or taken medication in relation to any of the following:

1. Y / N Heart or circulatory system (including but not limited to infarction, heart attack, angina, rheumatic fever, cardiac defect, arrhythmias, diseases of veins, arteries or valves, stroke) and/or any other symptom regarding circulatory system or heart.
2. Y / N Sexually transmitted diseases or Human Immunodeficiency Virus (HIV) or Acquired Immuno Deficiency Syndrome (AIDS) or ARC (AIDS related complex).
3. Y / N Neurological System (including but not limited to convulsions epilepsy, paralysis, Multiple Sclerosis, cerebral infarction(stroke), Alzheimer's disease, dementia) and/or any other symptom regarding the neurological system, which if referred to a doctor would result in a diagnosis.
4. Y/N Liver disorders (including but not limited to fatty liver, cirrhosis, hepatitis) and/or any other symptom regarding the liver, which if referred to a doctor would result in a diagnosis.
5. Y/ N Kidney/Renal disease or failure

In the last twelve months has any person listed above (Part A &/or Part C) ever:

6. Y/ N Been treated for Cancer, if yes, please explain:

7. Y/ N Been treated for Diabetes(sugar)/Hypertension(high blood pressure) , if yes, please explain: _____
8. Y/ N Been treated for Respiratory conditions, if yes, please explain:

9. Y / N Had an organ Transplant, if yes please explain:

10. Y/ N Had major surgery, if yes please explain:

11. Y/N Are you currently on medications? Please specify.

12. Females only: Are you pregnant, if yes please specify the number of weeks gestation:

Has any approved insurer within the last twelve months:

13. Y/N Declined an application for health insurance?

14. Y/N Required an increased premium or imposed special condition?

15. Y/N Cancelled or refused to renew an existing health insurance policy

Declaration

I hereby declare that the answers given and recorded herein are, to the best of my/our knowledge, complete and true as at this date.

I hereby authorize any registered medical practitioner, healthcare facility or approved insurer which has copies of my health records to release such information to _____ (name of approved insurer). A photocopy of this signed authorization shall be as valid as the original.

I understand and agree that any injury that occurred within twelve months before the date of this application or any sickness, the signs of which first appeared on or before the date of this application, are not covered by this contract unless fully disclosed on this application. Failure to disclose such information could result in denial of a claim and the cancellation of coverage.

I understand and agree that coverage shall not become effective until accepted by the approved insurer.

I understand that any changes in my health status after submission of application and prior to approval of coverage must be reported to the approved insurer.

Signature of Applicant: _____ Signature of Dependent (if applicable)

_____ Date: _____
DD/MM/YY

THIS APPLICATION WILL BE VALID FOR 30 DAYS FROM THE DATE OF SIGNATURE.

For Office Use Only
Comments from Approved Insurer

FAILURE TO DISCLOSE RELEVANT DETAILS OR GIVING MISLEADING INFORMATION MAY CAUSE YOUR APPLICATION TO BE DEEMED NULL AND VOID".

Savings and transitional provisions

20. A contract of health insurance that is in force immediately before the coming into force of regulation 17 shall, on the first annual renewal date of the contract of health insurance following the coming into force of regulation 17, be converted

into a contract of health insurance similar to the Standard Health Insurance Contract inserted by regulation 17 into the First Schedule to the principal Regulations, at a fair and reasonable rate determined in accordance with the same methodology as used in rating the contract of health insurance.

Made in Cabinet the 18th day of September, 2012.

Kim Bullings

Clerk of the Cabinet.

These Regulations were approved by the Legislative Assembly on the 21st day of November, 2012, by Government Motion No. 2 of 2012-13, in compliance with section 25 of the Health Insurance Law (2011 Revision).

Zena Merren-Chin

Clerk of the Legislative Assembly.