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APPLICATION REFERENCE NUMBER: \_\_\_\_\_

BRANCH: \_\_\_\_\_

## **APPLICATION FORM - HEALTHCARE PROVIDER** **to the ECCU/BAICO Health Insurance Support Fund**

### **Instructions:**

- Please use this Application Form:
  - If you are a Healthcare Provider who has provided healthcare services to an Insured Person that are the subject of one or more Approved Claims, and
  - You believe that you are legally entitled to receive some or all of the proceeds of that Approved Claim.
- Please read the Fund Information Brochure to understand how the Fund operates, and how to make sure that your Application Form is properly completed.
- If possible, please include all of your Approved Claims in one application, and ensure that they are listed in the table in Section 2.
- If BAICO has provided a pre-completed Application Form to assist you:
  - Please check the details to ensure that they are correct and complete. Any corrections should be clearly marked on the Application Form;
  - Ensure that you complete any missing details such as your telephone number, address and contact person;
  - Please note that the Approved Claims listed on BAICO's system as being payable to you have been included in Section 2. If you have since:
    - ◆ Been paid in full for these services, then you will need to **delete** those Approved Claims from your Application, as the Insured Person will have the right to be paid by the Fund; or
    - ◆ Been paid in part for these services (i.e. in excess of the deductible), you must indicate this in Section 2.
- If more space is needed (for instance, you need to add other Claims), please:
  - Check, complete and sign this Application Form;
  - Obtain a blank Application Form and:
    - ◆ Insert your Name in Section 1, and the additional Claims in Section 2;
    - ◆ If you have it, insert the same Application Reference Number as above;
    - ◆ Securely attach the additional Application Form/s to this Form; and
    - ◆ Sign any additional Application Form/s, and have the same witness also sign it as indicated.
- If possible, please arrange for all Insured Persons under the Approved Claims to sign a Supplementary Declaration confirming that:

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- They have not paid you in full or for any amount of that invoice and, if they have paid you an amount in excess of the deductible, the amount of that payment; and
- You are entitled to receive payment in respect of the proportion of the Approved Claim for which you have not received payment.

Supplementary Declaration Forms are available from your BAICO branch.

**Please note** that, if you do not arrange for Supplementary Declarations, then the processing of your Application is likely to be delayed until the Fund can ensure no competing applications are made with respect to any Approved Claims.

- If you want to apply to the Fund for Claims that have not yet been approved by BAICO, please wait until they are approved and then submit an additional Application Form listing those Claims.
- If you have received a partial payment in respect of services under the Approved Claim in excess of the deductible (i.e. which would reduce the amount you would be owed by BAICO), you must include details of that payment in this Application Form.
- Assuming your Application Form has been completed correctly (and that all Insured Persons have completed a Supplementary Declaration as requested above) please allow up to 90 days for processing. If no Supplementary Declaration has been completed in respect of any Approved Claim, processing for those Approved Claims will be deferred until the Trustee has processed all Applications from individuals.
- Please sign and date the Application Form, and also arrange for a witness who is over 18 years old to witness your signature, and sign where indicated.

**SECTION 1: Applicant Details**

Applicant's Name: \_\_\_\_\_

Applicant's Address: \_\_\_\_\_

Applicant's Phone number: \_\_\_\_\_ (daytime)

\_\_\_\_\_ (cell)

Contact person for queries: \_\_\_\_\_

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**SECTION 2: Approved Claim Information**

Please make sure that all Approved Claims that are the subject of this Application are listed below. Please ensure that only Claims that have been approved by BAICO are listed here. Please indicate the amount of any payment from or made on behalf of the Insured Person in excess of the deductible (i.e. that would have otherwise been payable to you by BAICO under the Approved Claim). If the amount is zero, please state this.

<b>Policy Number</b>	<b>Insured Person</b>	<b>Claim Number</b>	<b>Amount of Approved Claim<sup>1</sup></b>	<b>Amount of Invoice</b>	<b>Amount paid in respect of that invoice in excess of the deductible<sup>**</sup></b>

<sup>\*\*</sup> that would have otherwise been payable by BAICO to you for the Approved Claim.

<sup>1</sup> This is the amount payable by BAICO for that Approved Claim in accordance with the terms of the Health Insurance Policy.

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**SECTION 3: Supplementary Declarations**

If you wish to avoid a delay in the processing of your Application, please attach a completed and signed Supplementary Declaration for each Insured Person listed above. Supplementary Declaration Forms are available from your branch.

Please list all Insured Persons whose completed Supplementary Declarations are attached to this Application Form:

<b>Policy Number</b>	<b>Claim Number</b>	<b>Insured Person</b>

**SECTION 4: Declaration and Assignment**

- I have read the Fund Information Brochure and understand the rules that apply to making this Application to the Fund.
- I agree to be bound by the terms of the Fund’s Trust Deed and other rules concerning the Fund.
- I am the Healthcare Provider in respect of the Approved Claims listed in Section 2 of this Application, and believe that I am legally entitled to be paid some or all of the amount payable under each of those Approved Claims.
- I am aware that each listed Insured Person has assigned their Approved Claim to me, or that they have otherwise instructed BAICO to pay me the proceeds of that Approved Claim.
- I have not been paid in full for the services provided to any of the listed Insured Persons in respect of that Approved Claim.
- If I have received any amount in part-payment in respect of any Approved Claim (not including any deductible), the details have been included in this Application, and I understand that the amount I will be paid from the Fund will be reduced to reflect this.

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- In consideration for the Fund paying me an amount in respect of a particular Approved Claim, I assign all of my rights in respect of that Approved Claim to the Fund and, in doing so, give up my rights against BAICO under the Approved Claim.
- I understand that, if any Insured Person makes an Application to the Fund in respect of one or more of the Approved Claims that I have listed in Section 2, then I may not receive any payment in respect of that Approved Claim until the Trustee is properly satisfied as to who has the right to receive the payment.
- I agree that the Trustee, British American Insurance Company Limited (BAICO) and British American Insurance Company (Trinidad) Limited (BAT) may exchange information about the Approved Claims or my Application, provided that they use it only for the purpose of assessing or administering the Claim or my Application, and administering the Fund.
- If I am issued a cheque by the Trustee, and do not present that cheque for payment within 6 months of its date (in which case the cheque will have expired), then I agree that my Application will be void. In such a case, the Trustee will not owe me any money, and I will retain all rights with respect to my Claims.
- I declare that all of the information in this Application (including any attachments or authorised amendments of it) is true, correct and complete to the best of my knowledge.

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_

Name of Witness: \_\_\_\_\_

Date: \_\_\_\_\_

Name of Witness <sup>2</sup>: \_\_\_\_\_

<sup>2</sup> The witness must be over 18 years of age.



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**3. Supplementary Declarations**

Are all Supplementary Declarations listed in Section 3 of the Application attached to the Application?

Yes / No

If No, please ensure they are attached before submitting the Application. If you cannot do so, then please list missing Supplementary Declarations below:

<b>Policy Number</b>	<b>Claim Number</b>	<b>Insured Person</b>	<b>Amount of Approved Claim</b>

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