

OFFICE USE ONLY:

APPLICATION REFERENCE NUMBER: _____

BRANCH: _____

APPLICATION FORM – POLICYHOLDER / INSURED PERSON to the ECCU/BAICO Health Insurance Support Fund

Instructions:

- 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; and
 - Ensure that you complete any missing details such as your telephone number and address.
- 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 you are making an Application for an Approved Claim but you have asked BAICO to pay your healthcare provider the insurance proceeds, then you **must attach proof** that you have now paid that provider, and which shows the amount of that payment. If you do not, your Application for that Approved Claim is likely to be rejected or delayed.
- If you have paid more than the deductible, but less than the whole amount due, to the Healthcare Provider, then you and the Healthcare Provider should apply to the Fund using the Healthcare Provider Form and the Supplementary Declaration.
- If you have 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.
- Assuming your Application Form has been completed correctly, please allow up to 90 days for processing.
- 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.

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SECTION 1: Applicant Details

Applicant's Name: _____

Applicant's Address: _____

Applicant's Phone number: _____ (daytime)

_____ (cell)

SECTION 2: Approved Claim Information

Please make sure that all 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.

Policy Number	Insured Person	Claim Number	Amount of Approved Claim ¹
TOTAL APPROVED CLAIM AMOUNT			\$

SECTION 3: 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 person who is entitled to receive the payment for each of the Approved Claims listed in this Application.
- In consideration for the Fund paying me an amount in respect of a particular Approved Claim, I assign all of my rights in that Approved Claim to the Fund and, in doing so, give up my rights against BAICO under the Approved Claim.

¹ This is the amount payable to you by BAICO for that Approved Claim in accordance with the terms of the Health Insurance Policy.

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- I agree that the Trustee, British American Insurance Company Limited (BAICO) and British American Insurance Company (Trinidad) Limited (BAT) may exchange information about my Approved Claim or my Application, provided that they use it only for the purpose of assessing or administering my Claim or my Application, and administering the Fund.
- If I have included an Approved Claim in this Application but at some point I requested that BAICO pay someone else the proceeds of that Approved Claim (such as my healthcare provider), I:
 - Have since paid for the service in full; and
 - Have attached proof of that payment to this Application

(Please note: if another person has a right to receive payment under an Approved Claim, then you cannot be paid any amount unless you have paid that person or can otherwise prove that you are entitled to receive the proceeds of the Claim)

- 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 in respect of my Claims.
- I declare that all of the information in this Application (including any attachments or authorised amendments to it) is true, correct and complete to the best of my knowledge.

Signature of Applicant: _____

Date: _____

Signature of Witness ² : _____

Date: _____

Name of Witness: _____

Address of Witness: _____

² The witness must be over 18 years of age.

