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APPLICATION REFERENCE NUMBER: _____

BRANCH: _____

**SUPPLEMENTARY DECLARATION
FOR HEALTHCARE PROVIDER APPLICATIONS
(to be made by each INSURED PERSON or POLICYHOLDER)
To the ECCU/BAICO Health Insurance Support Fund**

Instructions:

- If possible, a Healthcare Provider should arrange for the completion of one (1) Supplementary Declaration for **each** Insured Person / Policyholder covered by their Application. In this Supplementary Declaration, the Insured Person or Policyholder (as relevant) is referred to as the **Insured Person**.
- The person who completes this Supplementary Declaration should be the person *who would have been entitled to be paid the Approved Claim if the Healthcare Provider had not been nominated as the payee*.
- Please **attach all** Supplementary Declarations to the Healthcare Provider's Application.
- Failure to provide a Supplementary Declaration for any Approved Claim may result in delayed payment or rejection of an Application as a whole or for particular Approved Claims.
- If the Healthcare Provider has only been paid part of their fee for the relevant services (ie above the deductible), this Form operates as an **Application by the Insured Person or Policyholder** to be paid a share of the relevant Approved Claim amount/s by the Fund.
- If this is the case, the Insured Person should:
 - read the Fund Information Brochure to understand how the Fund operates; and
 - attach **proof of this payment**.
- Assuming this Form and the Application Form have been completed correctly, please allow up to 90 days for processing.

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Applicant (Healthcare Provider) Name: _____

SECTION 1: Insured Person's Details

Insured Person's Name: _____

Insured Person's Address: _____

Insured Person's Phone number: _____ (daytime)

_____ (cell)

SECTION 2: Approved Claim Information

Please:

- make sure that all Approved Claims that are the subject of the Applicant's (Healthcare Provider's) Application relating to the Insured Person are listed below;
- ensure that only Claims that have been approved by BAICO are listed here;
- indicate the amount of any payment from or made on behalf of the Insured Person in excess of the deductible (ie that would have otherwise been payable to the Applicant (Healthcare Provider) by BAICO under the Approved Claim). If the amount is zero, please state this.

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Two examples of possible scenarios under the same Claim have been provided in the table below for your assistance.

Claim Number	Amount of Approved Claim	Cost of the Healthcare Providers' Service / Invoice amount	Amount of insurance deductible	Amount I have paid to my Healthcare Provider <u>in excess of the deductible</u>**
<i>Example 1</i>	\$120	\$150	\$30	\$60 (ie a total of \$90 of the invoice has been paid)
<i>Example 2</i>	\$120	\$150	\$30	zero

**** please do not include the amount of any deductible that you may have paid.**

In both Examples, the value of the Approved Claim is \$120, which is the maximum amount that the Fund would pay in respect of that Claim. The deductible of \$30 is payable by the Insured Person or the Policyholder. It does not form part of the Approved Claim, and is not covered by the Fund.

In *Example 1*, since the Healthcare Provider has been paid \$60 plus the deductible, and the Healthcare Provider is still owed \$60, the Healthcare Provider and the Insured Person will *each* receive \$60 from the Fund.

In *Example 2*, since the Healthcare Provider has received no payment in excess of the deductible, the Healthcare Provider will receive the *full amount* (ie \$120) of the Approved Claim. The Insured Person will not receive any payment from the Fund for that Approved Claim.

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SECTION 3: Declaration and Assignment

- I am the Insured Person in respect of the Approved Claims listed above.
- I have read the Fund Information Brochure and agree to be bound by the terms of the Fund's Trust Deed and other rules concerning the Fund.
- I am the person who would have been entitled to be paid the full amount of the Approved Claim, had the Applicant (Healthcare Provider) not been assigned the Approved Claim.
- I have listed in Section 2 above the Approved Claims relating to me where the Applicant (Healthcare Provider) is entitled to be paid some or all of the Approved Claim amount.
- I have directed BAICO to pay the amount of the proceeds of that Approved Claim to the Applicant (Healthcare Provider), or have otherwise transferred any interest that I may have had in the Approved Claim to the Applicant.
- If I have paid any amount for the services (in excess of the deductible) for those Healthcare Services:
 - I have indicated this above in Section 2;
 - I have attached proof of that payment to this Supplementary Declaration Form;
 - I agree that this Supplementary Declaration operates as my Application to the Fund for those Approved Claims; and
 - I understand that this may mean that the Applicant and I will each receive a share of the payment from the Fund.
- If I have not paid any amount for the services under the Approved Claim to the Applicant (Healthcare Provider) in excess of the deductible, I:
 - have made this clear in Section 2; and
 - understand that the Applicant (Healthcare Provider) is entitled to be paid the full amount of the Approved Claim from the Fund.
- In consideration for the Fund paying me and/or the Applicant (Healthcare Provider) an amount in respect of a particular Approved Claim, I assign all of my

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rights in that Approved Claim to the Fund and, in doing so, give up my rights against BAICO under the Approved Claim.

- 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 Claims, this Supplementary Declaration or my Application, provided that they use it only for the purpose of assessing or administering my Approved Claim or this 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 Supplementary Declaration (including any attachments or authorised amendments to it) is true, correct and complete to the best of my knowledge.

Signature of Insured Person: _____

Date: _____

Signature of Witness¹: _____

Date: _____

Name of Witness: _____

Address of Witness: _____

¹ The witness must be over 18 years of age.

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This section **MUST** be completed by the BAICO Branch before the Application is submitted to BAT.

1. Insured Person Identification

Insured Person Identity Verified: (please check box to indicate verification)

Identification Method: _____

BAICO Staff Member verifying Identification: _____

2. Third Party Interests

Are any Approved Claims in this Application subject to a direction to pay or assignment to a person other than the Insured Person or the Applicant (Healthcare Provider)? Yes / No

If Yes, please list those Claims and indicate whether proof of payment has been supplied by the Insured Person and is attached to this Form:

Claim Number	Insured Person	Proof of Payment submitted (Yes / No)	Amount of Approved Claim

If the person entitled to be paid the Approved Claim is not the Healthcare Provider, please bring this to the Trustee’s attention in a separate note attached to the Application.

3. Proof of Payment

If the Insured Person declared that they have paid any part of the Applicant’s services (in excess of the deductible), please ensure that proof of that payment has been attached to this Supplementary Declaration.