	FOR OFFICIAL USE
	Approved By and Date (DD/MM/YY):
Health Insurance Department Health Insurance Plan - Youth Application Form	Processed by CSR and Date (DD/MM/YY):
	No. of Members:
STOR THE RUNT	Existing Group #:
Participant's Name*:	
Group #: or Policy #: (***Please see note below)	
Email Address:	
Please indicate if:	
□ New Dependant □ Information Change	
	(Only complete fields that have changes)
Verification of Benefits Letter (please check one):	
If the letter is to be collected in person at HID, please allow two business days to complete	
Dependant of Participant	
(*Required)	
*Dependant's Name:	
(Mr./Miss/Ms.) (First Name)	
(Middle Name)	
*Address:	
*Parish:	
*Phone #:	
*Birthdate (dd/mm/yy):	mber:
Effective Date:	
***It is a requirement to include documentation showing that the participant is a parent or guardian of the dependant (e.g. birth certificate, or court documents for legal guardian).	
If the dependent is 19 to 21 years of age, the dependent must be enrolled in full time education in Bermuda. A letter from the Registrar must accompany this form.	
I, (Participant's Name), hereby o	certify that all the information
provided above is complete and accurate.	
Participant's Signature: Date (dd/mr	n/yy):
FORM CA18 – Youth Accounts Enrolment Form V03.00	
01 August 2018 Mailing Address: Health Insurance Department, P.O. Box HM 2160, Hamil Street Address: Sofia House, 2nd Floor, 48 Church Street, Hamilton H	