Health Insurance Department
Direct Debit Group Request Form
Please complete this form to subscribe to monthly direct debit billing for Health Insurance Department premium payments.

Group Details* (Please Print):

Name of Group:

Mailing Address:

Parish: Postal Code:

Primary Contact Person:_____ Telephone Number: --

Email Address: _____ Group Number:

☐ New Request for Direct Debit
☐ Change to Existing Direct Debit Record
☐ Cancellation
*all fields are mandatory

Employer Bank Details (Payer): Please provide the following information.

Name on Bank Account to be Debited:	
Bank Name (Bermuda Banks Only):	
Bank Account Number (Bermuda Banks Only): **(For accuracy, proof of account name and number portion of bank statement must be attached to this form)**	
Account Type (Chequing or Savings):	
Currency Type:	Bermuda Dollars Only

☐ A Letter of Authorization (LOA) from the Employer to validate authorized Signatories or the person(s) who can request this service on behalf of the Business/Group is attached or already filed with the Health Insurance Department

Terms & Conditions:

1. Health Insurance Department (HID) will debit the balance due amount shown on your monthly Billing Statement on the first business day of each month this request is in effect. If the first day of the month falls on a weekend or government holiday, the funds will be debited on the next working day.
2. In the event of Non-Sufficient Funds (NSF), or other errors, at the time of Direct Debit, the HID will be notified by the bank. Any service fees associated with NSF errors will be the Employer's responsibility. When this occurs, the Employer will be required to pay their account balance through other means. Direct Debit will resume with the next billing period.
3. Only acceptable account currency is Bermuda dollars. HID will not accept any other currency type.
4. The Employer is responsible for notifying HID of changes to the number of members covered under the Group's policy by the 15th day of the month prior to the next scheduled direct debit on the Employer's account. Failure to do so may result in additional payments, lapse in payment or termination of coverage.

Mailing Address: Health Insurance Department, P.O. Box HM 2160, Hamilton HM JX
Street Address: Sofia House, 2nd Floor, 48 Church Street, Hamilton HM 12
Phone: 441-295-9210 **Fax:** 441-295-9213 **Website:** www.gov.bm **Email:** hip@gov.bm

5. In order to cancel this agreement, HID must be notified in writing by the 15th day of the month prior to the next scheduled Direct Debit on the Group's account.
6. The Employer is responsible for notifying HID of changes to their bank account information by the 15th day of the month prior to the next scheduled Direct Debit on the Employer's account. Failure to do so may result in a lapse in payment and/or potential termination of their Group's coverage.
7. If there are legislative changes to the monthly premiums, this will automatically be updated in the Employer's Direct Debit Record. The new amount will be debited from the Employer's account as of the effective date mentioned in legislation.
8. If the Group's policy is terminated, either by your request or by lapse in payment, Direct Debit will cease to pull the funds from the account specified above. Upon re-enrollment of the Group policy with HID, the Employer will need to re-apply for Direct Debit.
9. HID reserves the right to remove your account from Direct Debit for any reason, including but not limited to issues that prevent or complicate the payment of funds from your bank.

Acknowledgement:

By signing the Monthly Premium Payment Direct Debit Request form, I/we **agree** to the terms and conditions noted above and hereby authorize Health Insurance Department to automatically debit my Bermuda bank account for the amount due on my Health Insurance account on the date the debit is scheduled, until this authorization is revoked.

Signature 1: _____ Date (dd/mm/yy): ☐☐/☐☐/☐☐

Print Name: _____ Company Name: _____

Position: _____

[If Required]

Signature 2: _____ Date (dd/mm/yy): ☐☐/☐☐/☐☐

Print Name: _____ Company Name: _____

Position: _____

For Office Use:

The first debit will be made on _____/_____/_____ (DD/MM/YYYY).

In the event of requested termination of policy or this offering, the termination effective date will be _____ (DD/MM/YYYY)

Effective Date (dd/mm/yy):

_____

Processed By and Date (dd/mm/yy):

_____

HID Manager Signature

_____