NHIB EMPLOYER/EMPLOYEE ENROLLMENT FORM

Employer ID: _____

Employer Name: _____

PLEASE USE BLOCK CAPITALS WHEN COMPLETING THIS FORM

Member Name:			Employment Date:	
DOB (mm/dd/yyyy):		Marital Status:	☐ Single ☐ Married ☐ Divorced ☐ Widowed	
Gender:	☐ Male ☐ Female		Occupation:	
Country of Birth:			NHIP #:	
Home Address:				
Area:				
Island:			Country:	
Phone:			Other Phone:	
E-Mail Address:				
Private Insurance:	☐ Yes ☐ No		Insurer:	

TCI Status Card #:		**Date From;**	
NIB#:		**Date From:**	
Passport # / Country:		**Date From/Thru:**	
Driver's License # / Country:		**Date From/Thru:**	
***Work Permit #:**		**Date From/Thru:**	

Declaration by Employer: I, _____ (full name of employer) declare that the particulars provided by the applicant in this enrollment form is true and correct to the best of my knowledge.

Signed by: _____ Date (mm/dd/yyyy): _____

Declaration by Employee: I, _____ (full name of applicant) hereby declare that the information I have provided in this application is true to the best of my knowledge and belief and I make it knowing that if I have made any false or misleading statements I am liable to be prosecuted under the National Health Insurance Ordinance.

Signed by: _____ Date (mm/dd/yyyy): _____

CONSENT TO RECEIVE AND RELEASE MEDICAL INFORMATION

I, _____ (full name of applicant), hereby give permission to the National Health Insurance Board to receive and release medical records or other information about my medical records to individuals who will be involved in the delivery of medical treatment to me. The authorization is indefinite while I am enrolled in the National Health Insurance Plan, unless I inform the National Health Insurance Board that I no longer authorize the disclosure of information.

Print Name: _____ Signature: _____

Date (mm/dd/yyyy): _____

FOR OFFICIAL USE:

RECEIVED BY: _____ DATE: _____

National Health INSURANCE PLAN

NHIB EMPLOYER/EMPLOYEE ENROLLMENT FORM

NATIONAL HEALTH INSURANCE BOARD ENROLLMENT REQUIREMENTS

EMPLOYEE ENROLLMENT

Please remit the following **along with** the completed enrollment form:

- ☐ **ORIGINAL COPY OF PASSPORT PHOTO PAGE**

- ☐ **ORIGINAL COPY OF DOCUMENT CONFIRMING LEGAL STATUS IN THE TURKS & CAICOS ISLANDS**
  - ☐ Turks & Caicos Islander Status
    - (i) Proof of Status (i.e. Turks & Caicos Islander Certificate/Stamp/Letter, TCI Status Card)
    - (ii) Employment Contract
  - ☐ Expatriate (employed by Government or Statutory Body)
    - (i) Employment Contract
    - (ii) "Government Employee" Stamp in Passport
  - ☐ Permanent Resident Certificate Holder (with the right to work)
    - (i) Permanent Resident Certificate
    - (ii) Permanent Resident Stamp in Passport
    - (iii) Employment Contract
  - ☐ Work Permit Holder
    - (i) Work Permit Card
    - (ii) Work permit renewal letter from employer and immigration renewal receipt
      *****Please note that this does not apply to first-time NHIP registrants or to first-time work permit applicants*****
  - ☐ Resident Permit Holders (Persons married to Turks & Caicos Islanders)
    - (i) Resident Permit Card
    - (ii) "Spouse of Turks & Caicos Islander" stamp in Passport
    - (iii) Employment Contract
  - ☐ Naturalization Certificate Holders
    - (i) Naturalization Certificate
    - (ii) Employment Contract

Applicants are to submit **all** required documents upon registration.

Declaration by Employee: I, _____ hereby declare that I understand the **limitations** as it pertains to my benefit coverage.

In accordance with the **Benefit (Amendment) Regulations 2016**; the following applies:

Regulation 5A

(2) The Plan will cover medical services in the Islands only, for the first six months of registration with the Plan, for a beneficiary who holds a work permit and his dependents.

(3) After the first six months mentioned in subregulation (2), such beneficiary and his dependents shall be entitled to receive medical services outside the Islands as follows—

(a) if he has made contributions to the Plan for 6 months to 2 years, maximum coverage of $200,000;

(b) if he has made contributions to the Plan for 2 years to 4 years, maximum coverage of $400,000;

(c) if he has made contributions to the Plan for 4 years to 6 years, maximum coverage of $600,000;

(d) if he has made contributions to the Plan for 6 years to 8 years, maximum coverage of $800,000;

(e) if he has made contributions to the Plan for 8 years to 10 years, maximum coverage of $1 million dollars;

(f) if he has made contributions to the Plan for greater than 10 years, unlimited coverage.

Signed by: _____

Date (mm/dd/yyyy): _____