HEALTH INSURANCE COMMISSION

CERTIFICATE OF COMPLIANCE – HEALTH INSURANCE

Guidance Notes for Form M

Use this form if you are applying for:

- Trade & Business License
- Trade & Business License Renewal
- Temporary Work Permit Application
- Temporary Work Permit Renewal
- Work Permit Grant Application (Grand Cayman)
- Work Permit Grant Renewal (Grand Cayman)
- Grant of Work Permit (Cayman Brac and Little Cayman)
- Renewal of Grant of Work Permit (Cayman Brac and Little Cayman)
- Residency Certificate for Persons of Independent Means
- BSP – Work Permit Grant
- BSP – Work Permit Renewal
- Special Economic Zone Work Permit
- Permanent Resident Annual Declaration Form
- Government Tenders

Keep these notes until you have received your Certificate of Compliance – Health Insurance from your Health Insurance Company (Approved Insurer).

Definitions:

- *Employee*: any individual who enters into or works under a contract of employment with an employer whether the contract be oral or written, express or implied, and the term includes a person whose services have been interrupted by a suspension of work during a period of leave or temporary lay-off.
- *Employer*: any person who has entered into a contract of employment with an employee, and includes any agent, representative or manager of such person who is placed in authority over an employee.
- *Insured person*: any person, group, or organization for whom or for which cover is provided by an approved insurer under the terms and conditions of a contract of health insurance.

Requirements:

To obtain a Certificate of Compliance – Health Insurance, please ensure that you have done the following:

I. Complete Section A of the Certificate of Compliance – Health Insurance Form in its entirety and present the completed form to your "Approved Insurer".

II. Ensure that all of your employees (including domestic workers, in a private home and those classified as legal residents working in these islands), are enrolled in a health insurance plan from an "Approved Insurer".

III. Under Section A, please note that the certificate will not be accepted as complete if an agency or other representative acting on behalf of the employer provides the authorized signature.

IV. Confirm that you have read, understood and signed the Employer Declaration, which is further detailed below:

We, the undersigned declare that the information given above is correct and confirm that the health insurance policy is current and in accordance with Section 5 of the Health Insurance Law (2013 Revision).

We also understand that making a false statement or representation, knowing the same to be false, is an offence under the Immigration Law, Labour Law, Trade & Business Licence Law, and will be subject to penalty including a fine and if upon summary conviction, may result in an imprisonment.

V. Under Section B, please ensure that your Certificate of Compliance Form has the signature and official date stamp of the "Approved Insurer" (it will not be accepted as complete if a health insurance agent or broker provides the authorized signature and/or stamp).

Last revised on 02-FEB-2016

Note: Please retain a copy of the signed form for your records. Submit the original to the Immigration Department, Department of Commerce and Investment, or other appropriate government agency.

FORM M

HEALTH INSURANCE COMMISSION

CERTIFICATE OF COMPLIANCE – HEALTH INSURANCE

Section A – To be completed by Employer

Name of Employer: _____ T/A _____

Name of Approved Insurer _____

Employee	Policy Number	Certificate Number	Effective Date

*Continue on a separate sheet if necessary

Employer's Declaration:

We, _____, declare that the above-stated information provided is correct and to the best of our knowledge and belief. We are aware that it is a criminal office to make a statement or representation that is false in a material fact which we know to be false or do not believe to be true.

_____	_____	_____
Print Name of Employer/Principal	Authorized Signature (Signature of an agency or other representative acting on behalf of the employer will **not** be accepted)	Date

Section B – To be completed by Approved Insurer

We, _____ confirm that the health insurance premiums are paid in full for the above-stated insured person(s) in agreement with our Company's records, as at the time of this document being completed and signed by us.

_____	_____	_____	Official Date Stamp of Approved Insurer
Print Name of Approved Insurer	Authorized Signature (of Approved Insurer)	Date	

FOR OFFICIAL USE:
Received By: Date:

2-Feb-16