HEALTH INSURANCE COMMISSION

APPLICATION FOR THE STANDARD HEALTH INSURANCE CONTRACT PREMIUM PAYMENT ASSISTANCE

Applies to Standard Health Insurance Contract coverage only.

☐ Group Policy ☐ Individual Policy

Name of Employer: _____ T/A _____

Telephone : _____ Email: _____

Contact Name: _____

Name of Approved Insurer _____

Employee name	Current Policy and/ or Certificate Number	Legal Resident: • Caymanian • Work Permit Holder • Married to Caymanian • Permanent Resident	Policy Termination Date	Number of Dependents	Is Insured Covered under another plan?

Latest Statement from Approved Insurer must be attached.

Provide Information to Demonstrate Need for Assistance: (Continue on a separate sheet if deemed necessary)

Employer's Declaration:

We declare that the above-stated information provided is correct and to the best of our knowledge and belief. We confirm that as a result of the COVID-19 Pandemic, our business establishment is no longer operational and unable to honor our health insurance premium payments. We are aware that it is an offence 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 applicant Authorized Signature Date

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HEALTH INSURANCE COMMISSION USE ONLY

☐ Approved ☐ Not Approved ☐ Deferred

HIC Authorized Signature: _____ Date: _____