FORM CR1

Bermuda Health Council BHeC

Application to Vary Time Requirements

This form is for use by insurers who wish to apply to vary time requirements to pay electronic health insurance claims per section 10 of the Health Insurance (Health Service Providers and Insurers) (Claims) Regulations 2012.

You may refer to the explanatory notes overleaf

PART A – INSURER/APPROVED SCHEME INFORMATION

Name of insurer/approved scheme [Note 1]:		
Street address [Note 2]:	Parish:	Postal Code:
Mailing address: ☐ Tick if same as street address [Note 2]	Parish:	Postal Code:
Authorized Officer [Note 3]:	Position [Note 4]:	☐ Mr ☐ Ms
Email (Authorized Officer) [Note 5]:	Phone No.:	Fax:

PART B – SUPPORTING INFORMATION

Number of insureds that would be affected by the time variation [Note 6]:

Indicate if the majority of insureds affected fall into these categories [Note 6]: ☐ Children ☐ Seniors

Why is the time variation being requested [Note 7]? *(Please attach supporting documentation)*

- ☐ Computer system failure
- ☐ Upgrading to new electronic data interchange system
  - What is the estimated time/date to complete upgrade? _____
- ☐ Other conditions *(Explain and attach relevant information to substantiate this condition)*

Outline what steps will be taken to meet the time requirements if the application is approved [Note 8]. *(Attach outline of the process)*

PART C – DECLARATION OF THE APPLICANT

NOTE: This form must be completed by an Authorized Officer of the Insurer and indicate he/she has read and accepted the following declaration [Note 9].

☐ I _____, hereby certify that the information contained in this application is true and correct in all material aspects. I acknowledge that any of the information provided in this form may be copied, recorded, or used by the Bermuda Health Council for the purpose of ensuring compliance under Section 10(1) of the Health Insurance (Health Service Providers and Insurers) (Claims) Regulations 2012. I will notify the Bermuda Health Council of any change in circumstances that may impact this application.

Date: _____

PART D – INTERNAL USE ONLY

Date received: dd / mmm / yy Reference No.:

☐ Approved ☐ Approval time period: _____ to _____

☐ Conditions: _____

☐ Declined Reasons: _____

Sterling House, 3rd Floor, 16 Wesley Street, Hamilton HM11, Bermuda | PO Box HM 3381, Hamilton HM PX, Bermuda
Phone: 441-292-6420 | Fax: 441-292-8067 | bdahealthcouncil@bhec.bm | www.bhec.bm

FORM CR1

Application to Vary Time Requirements

This form is for use by insurers who wish to apply to vary time requirements to pay electronic health insurance claims imposed by section 10 of the Health Insurance (Health Service Providers and Insurers) (Claims) Regulations 2012.

Explanatory Notes

Under section 9(1) an insurer must pay an electronic clean claim no later than thirty days from the date of the notice of receipt of the claim, where the claim was submitted by the time prescribed under paragraph 4(1)(a).

Under section 10(1) of the Health Insurance (Health Service Providers and Insurers) (Claims) Regulations 2012, an insurer who is unable to pay claims by the time prescribed under paragraph 9(1)(a) may apply to the Council for permission to vary the time requirement.

Under section 10(2) in determining an application, the Council may require the insurer to provide any documentation or to answer any questions which the Council may consider relevant.

The Regulations are on www.bermudalaws.bm. Supporting information is available on the Bermuda Health Council's website: www.bhec.bm under Health Insurance and Forms.

Instructions for completing this form:

This form can be completed electronically or manually. However, the **form must be submitted by email**. All parts of the form must be completed.

PART A: Application Details

1. **Name of Insurer /Approved scheme:** The name inserted should be the official name of the insurer
2. **Address:** Both the street and mailing addresses of insurer must be provided
3. **Authorized Officer:** The name of a senior Authorized Officer who will be the point of contact should the BHeC need to contact the insurer in regard to this application.
4. **Position:** The title of the position of this Authorized Officer.
5. **Email address** of the Authorized Officer.

PART B: Supporting Information

Part B must be completed to fully explain the application to vary time by:

6. indicating the number of insureds that will be affected by a time variation and if any particular group will be affected,
7. specifying why the variation is being sought, and
8. outlining steps that will be taken to meet the time requirements if the application is approved.

Any supporting information must be attached to this application. This supporting evidence must be clear and convincing to support a reasonable belief that the insurer is unable to pay electronic claims within 30 days.

PART C: Declaration of the Applicant

9. The Authorized Officer must read and accept the declaration and certify that the information contained in this application to vary time requirements is true and correct in all material aspects.

Submitting this form:

The completed form and the relevant documents should be submitted to Bermuda Health Council:

a. by email to healthcouncil@bhec.bm
b. include the term **"Application to vary time requirements"** in the subject line

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