FORM CR3

Application for an Exemption

This form is for use by health service providers who wish to apply for an exemption in accordance with section 15 of the Health Insurance (Health Service Providers and Insurers) (Claims) Regulations 2012.

You may refer to the explanatory notes overleaf

PART A – HEALTH SERVICE PROVIDER (FACILITY) INFORMATION

Name of health service provider [Note 1]:

Category of health service provider (if the business operates several services indicate all relevant categories e.g. a physician office that operates a practice and lab) [Note 2]:

☐ Allied health – specify: ______________________ ☐ Complementary /alternative – specify: ______________________

☐ Dental practice ☐ Lab ☐ Optometry practice ☐ Pharmacy ☐ Physician practice ☐ Psychology practice

☐ Other – Specify: ____

Street address [Note 3]:	Parish:	Postal Code:

Mailing address: ☐ Tick if same as street address [Note 3]

Office Manager /Health service provider[Note 4]:	☐ Mr ☐ Ms

Email (of above) [Note 5]:	Phone No.:	Fax:

PART B – REASON FOR APPLICATION FOR EXEMPTION [Note 6]:

Why is the insured portion being requested (please attach supporting documentation):

☐ health services provided are primarily those of an unregulated profession

☐ health service provider will discontinue practice within one year

☐ other conditions (explain and attach relevant information to substantiate such conditions)

PART C – DECLARATION OF THE APPLICANT

NOTE: This form must be completed by Office Manager or the health service provider and indicate he/she has read and accepted the following declaration [Note 7].

☐ 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 15 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: ______________________ Signature: ________________________________

PART D – INTERNAL USE ONLY

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

☐ Approved ☐ Approval time period: ____________________ to ____________________

☐ Conditions:

☐ Declined Reasons: ____

July 2012

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 CR3

Application for an Exemption

This form is for use by health service providers who wish to apply for an exemption in accordance with section 15 of the Health Insurance (Health Service Providers and Insurers) (Claims) Regulations 2012.

Explanatory Notes

Under section 15(2) notwithstanding paragraph 3(1)(a), the Council may grant permission to a health service provider to require payment of the insured portion of a procedure by an insured person where the Council is of the opinion that it would be unreasonable for the health service provider to comply with paragraph 3(1)(a).

When making an application the health service provider must provide a valid reason for making an application for an exemption.

The Regulations are on www.bermudalaws.bm. Supporting information is available on the Bermuda Health Council's BHeC'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 electronically**. All parts of the form must be completed.

PART A: Application Details

1. **Name of health service provider:** The name inserted should be the official name of the provider/facility
2. **Category of health service provider:** If the business operates several services indicate all relevant categories e.g. a physician office that operates a practice and lab
3. **Addresses:** Both the street and mailing addresses of health service provider must be provided
4. **Office Manager or health service provider:** The name of the person responsible for management of the practice who is to be the initial point of contact should the BHeC need to contact the health service provider in regard to this application
5. **Email address** of the office manager or health service provider

PART B: Reason for Application for Exemption

6. The applicant must provide clear and convincing evidence as to why the insured portion is being requested (please attach supporting documentation).
   Reasons that will be considered include:
   - health services provided are primarily those of an unregulated profession
   - health service provider will discontinue practice within one year
   - other conditions (explain and attach relevant information to substantiate such conditions)

PART C: Declaration of the Applicant

7. The Office Manager or health service provider must read and accept the declaration and certify that the information contained in this application to require payment by an insured portion of a procedure 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, include the term **"Require an exemption"** in the subject line, or
b. fax to 441-292-8067

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