BAF FINANCIAL & INSURANCE (BAHAMAS) LTD.
STUDENT ACCIDENT AND DISABILITY
ENROLLMENT FORM

NEW **RENEWAL**

NAME OF SCHOOL:
INSURED'S NAME:
INSURED'S DATE OF BIRTH (mm/dd/yy):
PARENT/GUARDIAN'S NAME:
STREET & POSTAL ADDRESS:
PHONE NUMBERS – HOME & CELL:
BENEFICIARY(S) NAMES:

CO-PAYMENTS	**PLAN A**	**PLAN B**
Co-Payment (Clinics)	$ 40.00	$ 40.00
Co-Payment (Specialist)	$ 55.00	$ 55.00
Co-Payment (Doctors Hospital)	$ 250.00	$ 250.00

BENEFITS	**PLAN A**	**PLAN B**
Annual Accident Benefit (Max)	$ 7,500.00	$3,750.00
Accidental Dental Expense	$ 750.00	$ 375.00
Accidental Death	$ 5,000.00	$2,500.00
Loss of Both Hands and Feet	$ 15,000.00	$7,500.00
Loss of Sight in Both Eyes	$ 15,000.00	$7,500.00
Loss of Hearing or Speech	$ 15,000.00	$7,500.00
Loss of Sight in One Eye	$ 7,500.00	$3,750.00
Loss of One Hand or Foot	$ 7,500.00	$3,750.00
Loss of Thumb, Index Finger, Great or Pinky Toe	$ 3,750.00	$1,875.00
Permanent Partial Disability Benefit	$15,000.00	$7,500.00

Please select (✓) the appropriate plan from below

Please enroll the named insured student in Plan (A) Premium $25.00	
Please enroll the named insured faculty/staff in Plan (A) Premium $30.00	
Please enroll the named insured student in Plan (B) Premium $15.00	
Please enroll the names insured faculty/staff in Plan (B) Premium $20.00	

NOTE: Children under the age of Two (2) are excluded

Parent's Signature _____ Print Name_____Date _____

Signature (School Rep) _____ Print Name _____Date _____