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 _____