BAF FINANCIAL
& INSURANCE (BAHAMAS) LTD.

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

NAME OF SCHOOL:
INSURED NAME:
INSURED DATE OF BIRTH (mm/dd/yy):
PARENT/GUARDIAN NAME:
STREET & POSTAL ADDRESS:
PHONE NUMBER(S):
BENEFICIARY(S):

BENEFIT	PLAN B
Annual Accident Benefit (Max)	$3,750.00
Co-Payment (Clinics)	$ 40.00
Co-Payment (Specialist)	$ 55.00
Co-Payment (Doctors Hospital)	$ 250.00
Accidental Dental Expense	$ 375.00
Accidental Death	$2,500.00
Loss of Both Hands and Feet	$7,500.00
Loss if sight in both eyes	$7,500.00
Loss of hearing or speech	$7,500.00
Loss of sight in One Eye	$3,750.00
Loss of One Hand or Foot	$3,750.00
Loss of Thumb or Index Finger, Great or Pinky Toe	$1,875.00
Permanent Partial Disability Benefit	$7,500.00

Please select (✓) the appropriate plan from below

Please enroll the named insured student in Plan (B) Premium $ 25.00	
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:_____

Authorized Signature (School):_____ Print Name:_____ Date: _____