BAF FINANCIAL
& INSURANCE (BAHAMAS) LTD.

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

NEW **RENEWAL**

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

BENEFIT	**PLAN A**	**PLAN B**
Annual Accident Benefit (Max)	$ 7,500.00	$3,750.00
Co-Payment (Clinics)	$ 40.00	$ 40.00
Co-Payment (Specialist)	$ 55.00	$ 55.00
Co-Payment (Doctors Hospital)	$ 250.00	$ 250.00
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
Insured must be referred to Doctors Hospital

Parent's Signature _____ Date _____ Authorized Signature
(School) _____ Name_____ Date
_____

Akhepran International Academy
P. O. Box EE17708
1 Bernard Road & Grant Street, Fox Hill
Nassau Bahamas
1(242) 324-8683

IDENTIFICATION CARD INFORMATION

Dear Parent/Guardian

In an effort for us to get the school identification cards for each scholar we ask that you furnish us with the requested information below.

We appreciate your co-operation in this matter.

PLEASE PRINT:

Name: _____

Age: _____ D.O.B: _____

Status: Kindergarten scholar; Primary Scholar; Senior Scholar; Junior Scholar

NIB #: _____

Passport #: _____

Parent: _____

Phone Contact: _____

Note: Please place the preferred person of choice for emergency contact as the parent for the identification card.

Akhepran International Academy

MEDICINE AUTHORIZATION FORM

I _____ hereby give my consent for
(Print Name of Parent/Guardian)

Dr. Jacinta Higgs - Principal of Akhepran International Academy or whomever she designates, to administer to and or allow my

child _____ of grade _____
(Print Name of Student)
to receive the following medication during school hours.

Name of Medication		Number (No.) of Doses		Signature and Time of Person who administered the medication	
Dates to be given	Morning Time	Mid-Day Time	Afternoon Time	Signature	Time Given

Parent/Guardian's Name _____ Date: _____
(Print Name of Parent/Guardian)

Parent/Guardian's Signature: _____ Date: _____

Students will ONLY be administered or given medication that has been prescribed by a MEDICAL DOCTOR. All students who present manifestations, signs, or symptoms of chronic, prolonged or contagious illnesses, diseases, sickness WILL NOT BE ACCEPTED IN SCHOOL WITHOUT A MEDICAL CERTIFICATE.