# *A GUIDE TO UNDERSTANDING*

## YOUR INDIVIDUAL HEALTH PLAN

***Updated July 2020***

COLINA

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# OUR VISION

To be recognized as a leading provider of innovative financial solutions which inspire trust and confidence, and enhance the well-being of our customers.

# OUR POLICY OF SERVICE EXCELLENCE

Our customers deserve our best efforts as well as our respect and courtesy. Our five-point Policy of Service Excellence is our commitment to deliver on our promise of protection and integrity.

1. **We are in business because of our customers.** Our policy is to sustain the highest quality of customer satisfaction through personal accountability and professional commitment. We will strive to treat all customers we encounter with courteous and prompt service. We will deliver thoughtful, appropriate and timely solutions and suggestions to meet our customers' needs.

2. **We offer confidence for life.** Our policy is to be direct, open, and honest with you at every phase of our relationship – before, during, and after the purchase. In servicing your everyday needs, we will maintain your trust and confidence – knowing that it is your right as a customer to understand fully your contract, its terms, obligations and benefits.

3. **We will listen to you.** Our policy as a market-leading insurance company is to deliver products and services that exceed your expectations. To do this we will continue to solicit your feedback to improve how we address your changing needs and develop products that suit your unique circumstances.

4. **We will respect you.** Our policy is to safeguard your personal information and allow it to be used only for the purpose it was given to us and as required by law.

5. **We will be responsive.** Our policy is to answer your questions and resolve issues promptly and accurately. We will keep our commitments to provide information and documents, return a call or pay a visit. We will strive continually to exceed your expectations.

# Keep this Guide for Future Reference.

## We've prepared this Guide to help you understand the important things you need to know about your health insurance plan. You can also find meanings to common healthcare terms.

This Guide is for informational purposes only, and therefore does not supersede or replace any part of your health insurance contract. The complete terms and conditions of your individual health plan can be found in the following policy documents delivered to you by your sales representative, all of which constitutes your entire contract.

- The Policy
- Schedule of Benefits
- Copy of the application for insurance
- Any amendments

You are advised to read your contract in its entirety, which along with this guide will help you to get a full understanding of your coverage and obligations and provide information you need to manage your health plan.

## Customer Relations

If you have any questions about your health plan, please email them to **healthbenefits@colina.com.**

**You may also call our Customer Relations Unit at 396-5100. Our Customer Service Representatives are available weekdays from 9am to 5 pm and will be more than happy to assist you in getting answers to your healthcare coverage questions.**

If you are unable to contact us during normal business hours, you may call us afterhours and leave a voicemail message including your name, member ID found on your health insurance card, and telephone number where you can be reached. A Customer Service Representative will return your call at their earliest opportunity

# Your rights and responsibilities as a Colina individual medical policyholder

**As a Colina policyholder, you have certain rights and responsibilities that may be exercised or required of you throughout the duration of your policy.**

You have the right to:

- Be treated with courtesy and respect.
- Receive a policy contract from your sales representative or agent.
- Be provided with information about your Individual Health plan.
- Be notified prior to your policy lapsing or terminating.
- File a formal complaint, as outlined in this guide, and expect a response to that complaint within a reasonable period of time.
- Expect your personal information to be kept private and confidential and used appropriately.
- Be notified about changes to your premium.
- Be informed as to why, should your claim be denied.

# You also have responsibilities that require you to:

- Read carefully all questions on the application for insurance and disclose true and accurate information to prevent your policy from being voided or claim from being denied
- Pay premiums on time and in accordance with the terms of your policy contract, to avoid the suspension of benefits or termination of your policy.
- Read all policy documents that form part of your policy contract and all material distributed by the plan explaining policies and procedures regarding services and benefits.
- Read all printed or electronic policyowner notifications and reminders to better manage your policy and prevent it from lapsing.
- Take your and your dependents' Colina identification card with you at all times and use it when accessing medical care.
- Notify us if you changed your address or phone number, even if these changes are only temporary.
- Pay all applicable co-payments, deductibles, and coinsurance amounts required under your plan, where applicable.
- Review your Explanations of Benefits (EOB) statements closely to ensure they accurately reflect the services you received.

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# Common Health Insurance Terms You Should Know

**Regardless of which health insurer you choose, there are some common terms associated with your health insurance plan that you should become familiar with. You should understand the features of your health insurance policy to know what it covers and what you will be required to pay out of your own pocket.**

**Annual Maximum** – the maximum amount a health plan will pay in benefits for a covered person during any given calendar year.

**Calendar Year** – the 1st day of January to the 31st day of December (both days inclusive) in any given year.

**Co-insurance** – a co-sharing agreement under a health insurance plan which provides for the insured and the insurer to pay a specified percentage of the medical expenses, after the deductible has been met by the insured. For example, an 80/20 coinsurance plan with a $250 deductible for prescription drugs requires the insured to pay 20% of the covered costs after the deductible has been paid, while the insurance company will be liable for the remaining 80%.

**Co-payment** – the flat amount you pay to a healthcare provider or pharmacy at the time of service. Copayments vary depending on your plan and the services you receive. For example, you may have a $35 or $50 copayment for a doctor's office visit.

**Co-ordination of Benefits (COB)** – the practice of ensuring that insurance claims are not paid multiple times, when an insured is covered by two health plans at the same time and that payments by both plans do not exceed 100% of covered charges. COB determines which plan is primary and which is secondary

**Deductible** – the dollar amount you pay toward certain medical expenses each Calendar Year before your insurance plan starts paying any of the cost. Check your plan Schedule of Benefits to see what deductibles you have (if applicable).

**Dependent** – an individual other than the policyholder who is eligible to receive health care services under the health plan. Generally, a dependant is limited to a spouse and unmarried child including an adopted, stepchild or foster child.

**Exclusions** – services not covered under a health insurance plan. The insured is expected to pay the full cost of non-covered services out of their own pocket.

**Explanation of Benefits (EOB)** – a statement sent by the insurer to the insured person explaining what medical treatment and/or services were paid for on their behalf and the amount they are responsible for. An EOB contains useful information to help you track your healthcare expenses and medical services received in the past.

**In-patient** – A person who is receiving medical treatment that requires hospital stay in excess of 24 hours.

**Lifetime Maximum Benefit** – the maximum amount a health plan will pay in benefits for a covered person during that individual's lifetime. In other words, once you've reached this limit, you will no longer be covered.

**Medical Provider** – a person or place that gives you medical care. Providers include doctors, hospitals, retail clinics, urgent care centers, and other healthcare professionals and facilities

**Medically necessary** – health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms.

**Non-Participating Provider** – A medical provider or facility that has not signed a contract with an insurer and, therefore is not approved to be a part of the provider network.

**Out-patient** – A person who is receiving medical care in a doctor's office, clinic, day surgery centre or hospital whose treatment requires a stay of less than 24 hours.

**Participating Provider** – A medical provider or facility that contracts with an insurer to provide services for an insured and becomes a part of the provider network.

**Pre-Certification** – approval in advance by the insurer for a "medically necessary" and "covered" medical procedure or service, or an elective admission to a Hospital for care.

**Pre-Existing Condition** – any Illness or Injury (including pregnancy, Complications of Pregnancy, or pregnancy-related conditions), or any complication resulting from such Illness or Injury:

1. Which existed on or before the commencement of health insurance coverage.

2. For which a Covered Person received medical or surgical treatment or advice within a specified time frame before the commencement of health insurance coverage.

3. For which symptoms were present, on or before the commencement of health insurance coverage, whether or not the symptoms were related to the condition.

Charges incurred for any Pre-Existing Condition, as defined above, are **not** covered under your health plan until after a person covered under your health plan has been insured for **twelve (12) consecutive months**.

**Primary Insurance** – The insurance company that has first responsibility for payment of a claim.

**Referral** – A written recommendation by an insured's primary care physician or a specialist that the insured see another physician or specialist.

**Schedule of Benefits** – a list of the various services covered under a health insurance plan, outlining the responsibility of the Company and the insured persons.

**Usual, Customary, and Reasonable Charge** charges of health care providers that are consistent with charges from similar providers for identical or similar services in a given geographical area.

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# About Colina's Individual Medical plans

Colina's Individual Medical **(Shape)** plans are managed care major medical plans which provide all essential health benefits like ***emergency services, primary & specialist care, surgical services, hospitalization, overseas care, organ transplants, preventive care, prescription medication, maternity and newborn care*** and much more, subject to the terms, conditions, limitations and exclusions of your policy contract. We have Individual Medical plan options with varying levels of benefits to suit your needs and budget.

## Managed care plans are a type of health insurance.

One of the goals of managed care is to reduce cost and control the cost of health care for insureds by forming provider networks and contracting with providers and medical facilities to provide care for insureds at reduced costs. Preventative care is a feature of managed care plans.

## Your premium due date

Timely payment of premiums is important to ensure your policy remains inforce and that you are able to access medical care. Premiums are due and payable on the **1st day of each month.**

## Premium payment options

We offer a range of premium payment options including:

- Over-the-counter payments at your nearest Colina location.
- Salary deduction via your employer
- Posted Dated Cheques
- Pre-Authorized Cheques/Direct Debit
- Online banking

## Premium arrears & suspension of benefits

Your policy will be in arrears whenever the premiums are not paid by the due date. If your policy is more than 30 days in arrears, your benefits will be suspended and you will not be able to access medical services through your health plan. **It's your responsibility to ensure that your premium payments are up to date.**

## Policy Termination

Colina has the right to terminate your policy for the following reasons:

- If premiums are more than 90 days in arrears, and provided prior written notice was given in advance of the termination date.
- When the maximum benefit amount under your policy has been paid on behalf of a covered person.
- Misrepresentation on the Application for Insurance or fraud in obtaining coverage.

## Changes to your premium

Your premium can change from time to time. When this occurs, we will write to the Policyholder to let them know what the new premium will be. It will be the policyholder's responsibility to ensure that the new premium is submitted, to avoid suspension of benefits or policy termination. Policyholders who pay their premiums via any form of standing payment instructions such as Salary Deduction or Post Dated Cheque (PDC) will be required to meet with their sales representative or visit any Colina location to complete a plan adjustment form.

## Your health insurance ID card

All covered persons under your plan will receive an ID card with their own Member ID. Your Member ID is on the card which identifies you as a covered person. You are required to present this card whenever you visit a provider to receive medical services. Confirm that your name and date of birth on the card are correct and contact our Customer Relations Unit about any discrepancies or to request a replacement card in the event it is lost or stolen.

## Waiting periods

It's the period of time specified in a health insurance policy which must pass before some or all of your health care coverage can begin. The waiting periods under your health insurance plan are as follows:

- No benefits will be payable for expenses incurred by a covered person within the **first 90 days** after the effective date of the policy except for:

  1. Services rendered for infections; and
  2. Services rendered for accidents and/or emergencies.

- No benefits will be payable for pre-existing conditions within the first 12 months after the effective date of the policy.
- No benefits will be paid for pregnancy, complications of pregnancy or pregnancy-related conditions if conception occurs within **12 months** of the effective date of the policy.

## Limitations and Exclusions

Your plan does not provide coverage for all health care expenses and includes exclusions and limitations. These exclusions and limitations are outlined in your Policy Contract. Read your Policy Contract carefully to determine which health care services are covered benefits and to what extent.

## Choosing a medical provider (within The Bahamas)

Colina has an extensive local provider network. When accessing medical care, we strongly encourage you to choose a 'Participating Provider' from our list of network providers in your provider booklet or on our website at www.colina.com in order to minimize your out-of- pocket costs. You may also contact our in-house Medical Unit at 396-5100 who will be happy to assist you with coordinating your care. If you choose to receive medical care from a 'Non-Participating Provider' Colina **will only pay 50% of Usual, Customary, and Reasonable Charges (URC), after applicable co-payment, coinsurance & deductible have been met, and you will be responsible for the balance.**

## Choosing a medical provider (outside The Bahamas)

Colina also has an extensive overseas provider network. Prior to travelling overseas to obtain medical care, you will be required to contact our in-house Medical Unit at 396-5100 who will coordinate your care through our overseas Third Party Administrator (TPA), Sanus Health Corporation. If you choose to receive medical care from a 'Non-Participating Provider', Colina **will only pay 50% of Usual, Customary, and Reasonable Charges (URC), after applicable co-payment, coinsurance & deductible have been met, and you will be responsible for the balance.**

## Case Management & Coordination of Care

Case management services are provided by Colina's in-house Medical Unit and our overseas TPA Sanus Health Corporation, which comprises a number of certified Registered Nurses and physicians with specialized training. These experts use their clinical experience to evaluate the appropriateness and cost-effectiveness of medical care provided to our insureds, while in hospital and are able to coordinate all aspects of your care and provide guidance when you need it the most.

## Preventative Care

All Colina health plans offer an annual capped preventative care benefit for recommended routine check-ups and screenings to help you avoid getting sick and improve your health. Charges within this capped benefit are at no out-of-pocket cost to you. Any expenses above capped benefits will be the responsibility of the Policyholder. See your Schedule of Benefits for more details about this benefit.

## What to do in the event of a local medical emergency

In the event of a medical emergency, call 911 or go to the nearest private hospital emergency room. You will be required to make payment as stipulated in your Schedule of Benefits and according to the classification of the care administered. A referral is not required for emergency care. The Pre-Certification Program requires that a covered person, or someone on his behalf, contact the Company as soon as possible, but no later than 48 hours after a weekday admission, or within 72 hours if the admission is on a weekend or legal holiday, for an Emergency confinement to hospital.

## Limited or non-covered services

Like most major medical expense plans, your Individual Medical plan includes exclusions and limitations. An exclusion states that under certain circumstances benefits will not be paid; a limitation states that only limited benefits will be paid. Your policy contract outlines those medical expenses not covered under your policy or with limited benefits.

### Treatment needed as a result of someone else's fault

Your policy contract contains a Subrogation clause which allows Colina to recover the cost of your medical treatment as a result of a negligent third party e.g. a motor vehicle accident in which you are a victim. Colina will pay your medical expenses upfront and then go after the negligent third party on your behalf.

### Adding or removing dependents

As your life situation changes you may need to add or remove members on or from your health plan, respectively. Only the policyholder or authorized person can add or remove persons.

The following is a list of eligible persons who can be added to your health plan:

1. A Spouse

2. Each unmarried child under 19 years of ages
    a. Natural child;
    b. Legally adopted child;
    c. Child under legal guardianship; and
    d. Stepchild

3. Each unmarried child between the ages of 19 and 25, provided the child is a full-time student in an accredited educational institution, and is not employed on a full-time basis.

4. A mentally retarded or physically handicapped child

### Adding a newborn to your health plan

A new-born child may be added to an existing health plan and become eligible for coverage with effect from his or her date of birth, provided the enrollment application is completed and submitted to the Company within (31) days of his or her birth, accompanied by the 1st month premium. We strongly recommend that you add your new-born dependent child as soon as possible to prevent any delays in receiving benefits.

### Requirements for your dependent(s) ages 19 - 25

You will be required to provide proof of full-time student status twice a year for your dependent(s) ages 19 – 25, no later than January 31st to verify coverage for the Spring Semester, and no later than September 30th for the Fall Semester.

### Auto-conversion of dependent coverage

Your dependent child, upon attaining age 19 and who is not a full-time student can make application to convert to his/her own Individual Medical policy without evidence of insurability. Application must be submitted along with the first month's premium, within 30 days of terminating of coverage. For more information about this feature, contact your sales representative or our Customer Relations Unit.

### Upgrading or downgrading your existing health plan

Policyholders of Shape C or D, are permitted to upgrade to a Shape B or C plan by meeting the necessary medical underwriting requirements and paying the applicable policy administration fee. Any upgrade to a Shape A plan will be considered a new policy subject to full medical underwriting requirements, payment of the applicable policy administration fee, and waiting periods.

Policyholders of Shape A, B, or C are also permitted to downgrade to Shape B, C, or D plan. Medical underwriting, waiting periods and policy administration fee do not apply.

### Life & Accidental Death & Dismemberment Insurance

A life insurance benefit is available under this policy to the Policyholder and to their eligible dependents. Accidental Death & Dismemberment benefits only apply to eligible Policyholders. Benefits will be payable as stated in the Schedule of Benefits and Policy Contract to the individual(s) designated in writing as beneficiary(ies) of the Policyholder's Life Insurance benefits.

### Change of beneficiary

As your personal circumstances change, you may wish to revisit your beneficiary designation. For information concerning a change of beneficiary, contact your sales representative or our Customer Relations Unit.

### How to file a claim

Choosing a "Participating Provider" from our provider networks eliminates the need for you to file a claim, for the most part. However, if you choose to receive care from a "Non-Participating Provider", you will have to pay the provider in full for services and subsequently file a claim with us for reimbursement. We aim to settle claims within 3 – 5 business days.

To file a claim for reimbursement, simply follow these steps:

- Have your physician or the medical facility complete the claim form and ensure that the following areas are completed.
    - Patient Name
    - Date(s) of Service
    - Type of Service(s)
    - Diagnosis Codes
    - Procedure Codes
    - Amount Paid for the Service
    - Total Charges for the Service
- Only original documents will be accepted for processing
- Under no circumstances should liquid paper be used on a claim form
- Changes made to the form must be crossed out and initialed.
- Payment receipts should be submitted along with your claim

All claims must be submitted within six (6) months from the date of service. Claims submitted outside of this time frame will be denied for untimely filing.

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# When is Pre-certification Required?

Procedures or services requiring pre-certification or pre-authorization from the Company, prior to services being rendered, are outlined in detail in your Policy Contract under the Pre-Certification Program. A covered person must follow this program in order to receive full benefits payable under his/her policy. The provider office will typically obtain the required pre-certification, however, it is ultimately the covered person's or policyholder's responsibility to ensure that the pre-certification requirements have been met.

If you fail to obtain a pre-certification, **Colina will only pay 50% of Usual, Customary, and Reasonable Charges (URC), after applicable co-payment, coinsurance & deductible have been met, and you will be responsible for the balance.**

You will be required to obtain pre-certification prior to using any of the following services:

- Hospital Admission
- Overseas Care
- Surgical Services
- Rehabilitation, Skilled Nursing Facility Confinements
- Home Health Care
- Diagnostic Procedures such as MRI, CAT Scans
- Air Ambulance or Air Transportation
- In-patient treatment
- Behavioral Health Disorders such as drugs or alcohol addiction
- Human Organ Transplants
- Certain medications
- Return/Repatriation of Deceased

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# When is a referral required?

**If you require specialist care locally or overseas, you must adhere to the following referral rules.**

**Referrals are valid for one (1) month from the date of issue.**

**Overseas Care**

Colina must coordinate and approve all non-emergency overseas medical services. It is your responsibility to provide Colina with a letter of medical necessity and referral from a Specialist in The Bahamas to a Specialist overseas for a second opinion or for treatment not available locally. Should you require emergency care while travelling, please access the nearest medical facility and/or contact Sanus Health Corporation, using the number on the back of your ID card. If you fail to obtain a referral, which must be approved by Colina, prior to obtaining non-emergency medical services overseas, Colina will only pay 50% of Usual, Customary, and Reasonable Charges (URC), after applicable co-payment, coinsurance & deductible have been met, and you will be responsible for the balance.

**Paramedical Services**

To obtain the following services, we require a referral from your attending physician, prior to obtaining medical services. If a referral is not obtained, prior to obtaining medical services, Colina will only pay 50% of Usual, Customary, and Reasonable Charges (URC), after applicable co-payment, coinsurance & deductible have been met.

The following services require you to have a referral.

- Chiropractic Care
- Physiotherapy
- Speech Therapy
- Masseurs Therapy

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# How your Individual Medical Plan works

**How your Individual Medical plan works.**

Our Individual Medical plans provide a range of coverage options for you to choose from. The amount of premiums and out-of-pocket expenses you pay to obtain healthcare services is based on your plan's benefits, co-payments, coinsurance and deductibles.

Here are some important things to consider when choosing a plan:

**Plan options:** Colina has four (4) Individual Medical plan options with different coverage levels: Shape A, Shape B, Shape C, and Shape D. Shape A offers the highest level of coverage at a higher monthly premium and Shape D offers the lowest level of coverage at a lower monthly premium.

**Monthly premiums:** This is the amount you pay your insurance company for your coverage each month. It is important to consider more than just the monthly premium cost when selecting a plan. Factors such as attained age, gender and smoking status help to determine the insureds applicable premium.

**Out-of-pocket expenses:** Medical insurance coverage requires insureds to pay a portion of the cost of their healthcare services. Your co-payments, coinsurance and deductibles are considered your out-of-pocket expenses, in addition to your monthly premiums. It is important to know how much you have to pay out of your pocket in order to obtain healthcare services. Choosing a plan with a lower monthly premium will cover less benefits and require you to pay more out-of-pocket expenses for healthcare services. On the other hand, choosing a plan with a higher monthly premium will cover more benefits but require you to pay less out-of-pocket expenses for healthcare services.

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# How your Individual Medical Plan works

The following example illustrates the cost sharing for the following healthcare services obtained by a 30 year old female (non-smoker) insured under each SHAPE plan, in accordance with the plan's Schedule of Benefits attached to the policy contract.

| | | ***SHAPE A*** | | ***SHAPE B*** | | ***SHAPE C*** | | ***SHAPE D*** | |
|---|---|---|---|---|---|---|---|---|---|
| | | Monthly Premium - $306.62 | | Monthly Premium - $274.15 | | Monthy Premium - $178.63 | | Monthly Premium -$140.32 | |
| **MEDICAL BENEFIT** Lifetime Maximum | | $2 million | | $1 million | | $500,000 | | $500,000 | |
| | ***Healthcare*** Expenses | **Insured Pays** | **Colina Pays** | **Insured Pays** | **Colina Pays** | **Insured Pays** | **Colina Pays** | **Insured Pays** | **Colina Pays** |
| Specialist Visit | $250$ | 50 | $200$ | 50 | $200$ | 50 | $200 | $100 | $150 |
| Lab Test | $500 | $100 | $400 | $100 | $400 | $100 | $400 | $100 | $400 |
| Prescription Drug | $1,000 | $200 | $800 | $200 | $800 | $200 | $800 | $400 | $600 |
| MRI Scan | $1,500 | $200 | $1,300 | $200 | $1,300 | $200 | $1,300 | $200 | $1,300 |
| Surgical Expenses (In-Hospital) | $20,000$ | 0 | $20,000 | $4,000 | $16,000 | $8,000 | $12,000 | $8,300 | $11,700 |
| Hospital Expenses (Doctors Hosp.) | $50,000 | $300 | $49,700 | $10,600 | $39,400 | $20,600 | $29,400 | $20,900 | $29,100 |
| Emergency Room (Life Threatening) | $6,000$ | 0 | $6,000$ | 0 | $6,000$ | 0 | $6,000 | $2,400 | $3,600 |
| ***Total Expenses*** | **$79,250** | **$850** | **$78,400** | **$15,150** | **$64,100** | **$29,150** | **$50,100** | **$32,400** | **$46,850** |

The above chart illustrates the following:

- Under a Shape A plan, with the highest monthly premium of $306.62 and total medical expenses of $79,250, the insured paid total out-of-pocket expenses of $850 and the health plan paid $78,400.
- Under a Shape D plan with the lowest monthly premium of $140.32 and total medical expenses of $79,250 (same as the insured with a Shape A plan) the insured paid total out-of-pocket expenses of $32,400 and the health plan paid $46,850.

# Understanding Your Explanation of Benefits (EOB)

**Each time Colina processes a claim submitted by you or your healthcare provider, we explain how we processed it in the form of an Explanation of Benefits (EOB).**

The EOB is not a bill. It simply explains how your benefits were applied to that particular claim. It includes the date you received the service, the amount billed, the amount covered, the amount we paid and any balance you're responsible for paying the provider. (We recommend you keep all of your EOBs)

Each time you receive an EOB, review it closely and compare it to the receipt or statement from the provider. If you observe any discrepancies between your EOB and the services you received of your statement from the provider, contact our Customer Relationship Unit immediately.

### Changing your personal information

You are required to advise Colina when any of your personal details change such as your mailing address, telephone number(s) and email address, otherwise you might not receive important communications concerning your policy.

### Relocating outside The Bahamas

As your policy is intended to cover insureds residing in The Bahamas, should you change country of residence and relocate outside of The Bahamas, except as a full-time student studying abroad, please notify us immediately.

### Resolution of Complaints

***All grievances or complaints must be directed to the Customer Relations Unit by calling 396-5100 or emailing them to healthbenefits@colina.com.***

*At Colina, we aim to resolve all grievances amicably and as quickly as possible. Should you wish to appeal a decision communicated by the Customer Relations Unit, you may do so through Colina's formal complaints process by filing a written complaint addressed to Complaints Management Unit, Colina Insurance Limited or Complaints@colina.com*

## COLINA OFFICES

**New Providence**
P.O. Box N 4728

**Corporate Office**
308 East Bay Street
Nassau, NP, Bahamas
Tel: (242) 396-2100
Fax: (242) 393-1710

**Health Division**
**12 Village Road**
Nassau, NP, Bahamas
Tel: (242) 396-5100

**21 Collins Avenue**
Nassau, NP, Bahamas
Tel: (242) 356-8300
Fax: (242) 328-2247

**Rosetta Street**
Nassau, NP, Bahamas
Tel: (242) 397-2200
Fax: (242) 356-3564

**Carmichael Road**
**Walk In Plaza, 2nd Floor**
Nassau, NP, Bahamas
Tel: (242) 361-2442
Fax: (242) 361-0731

**56 Collins Avenue**
Nassau, NP, Bahamas
Tel: (242) 397-7600

**Carter St.**
**Oakes Field**
Nassau, NP, Bahamas
Tel: (242) 322-5665
Fax: (242) 322-7162

**Colina Mortgage Corporation**
**12 Village Road**
Nassau, NP, Bahamas
Tel: (242) 396-4100
Fax: (242) 396-4112

**Grand Bahama**
P.O. Box F-42455

East Mall & Poinciana Dr.
Freeport, GB, Bahamas
Tel: (242) 352-3223
Fax: (242) 352-4609

**Abaco**
P.O. Box AB-20471

Don McKay Blvd.
Marsh Harbour, AB, Bahamas
Tel: (242) 367-3432
Fax: (242) 367-3299

**Exuma**
P.O. Box EX-29336

The Turnquest Star Centre
Georgetown, Exuma
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Tel: (242) 336-3127
Fax: (242) 336-3129

**Cayman Islands**
**Grand Cayman**

Cayman Insurance Centre Ltd.
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**Turks & Caicos**
**Providenciales**

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Providenciales

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