PROVIDER APPLICATION FORM
EB 197

PLEASE USE BLOCK LETTERS TO COMPLETE THIS FORM AND WRITE LEGIBLY.

Section A

NAME OF APPLICANT/PROVIDER[2]

TYPE MEDICAL ☐ OPTICAL ☐ DENTAL ☐ PHARMACY ☐ LABORATORY ☐ RADIOLOGY ☐

SPECIALTY

OTHER

REGISTRATION AUTHORITY

PROFESSIONAL REGISTRATION NO. **TRN[1]** ___ — ___ — ___

Section B

PRACTICE LOCATION ADDRESS

CITY **PARISH**

OPERATING DAYS & HOURS

IS LOCATION CURRENTLY IN OPERATION? YES ☐ NO ☐ **NAME OF CONTACT PERSON**

TELEPHONE ___ — ___ — ___ **FAX** ___ — ___ — ___

EMAIL _____ @ _____ . _____

Section C

ADDITIONAL PRACTICE LOCATION

CITY **PARISH**

OPERATING DAYS & HOURS

IS LOCATION CURRENTLY IN OPERATION? YES ☐ NO ☐ **NAME OF CONTACT PERSON**

TELEPHONE ___ — ___ — ___ **FAX** ___ — ___ — ___

EMAIL _____ @ _____ . _____

Section D

HAS YOUR LICENCE EVER BEEN REVOKED OR SUSPENDED? YES ☐ NO ☐

IF YES, PROVIDE PROOF OF REINSTATEMENT

PROVIDER'S SIGNATURE _____ **DATE** _____

ADDITIONAL PROVIDER'S SIGNATURE _____ **DATE** _____

INFORMATION ON REVERSE SIDE TO BE COMPLETED

PROVIDER DATA:

1. Are you a permanent resident, citizen or national of another country? ☐ Yes ☐ No If yes, please state:_____
2. Are you a US citizen, resident or green card holder? ☐ Yes ☐ No
3. Taxpayer Identification Number (TIN) (if applicable): _____
4. Where do you pay taxes? _____
5. Do you pay taxes in any other jurisdiction? ☐ Yes ☐ No If yes, please state: _____
6. Have you recently changed your residential or mailing address? ☐ Yes ☐ No
7. If yes, please state new address _____

(Please attach proof of address)

Section E

FOREIGN ACCOUNT TAX COMPLIANCE ACT (FATCA) CERTIFICATION

Certification for Non-US Person

I certify that I the undersigned am **NOT** a citizen, national, resident, or green card holder of the United States. I further agree to advise Guardian Life Limited as soon as I become aware of any changes that would render this declaration invalid.

…….. …….

Signature of Non-US Customer **Date**

Certification for US Person

I certify that I the undersigned **am** a citizen, national, resident or green card holder of the United States. I further confirm that the Taxpayer Identification Number (TIN) provided above is correct (or I am awaiting a number to be issued to me).

…….. ……

Signature of US Customer **Date**

POLITICALLY EXPOSED PERSONS (PEP)/PUBLIC FIGURES:

1. Do you, any immediate family or close associates, currently serve or previously served in the capacity of an official/senior official in the administrative, legislative or executive division of the government, military or judiciary of your country of residence or in any other foreign country government? ☐ Yes ☐ No
2. Do you, any immediate family or close associates, currently serve or previously served in the capacity of assistant commissioner or higher of the police force or as a senior executive of a state owned company of your country of residence or a foreign government? ☐ Yes ☐ No
3. If you have ticked "Yes" to any of the above, please state the capacity? _____

Section F

AUTHORIZATION, DECLARATION AND CONSENT:

I understand that the information provided in this form will enable Guardian Life Limited to manage operations and risks and allow for the enhancement of customer experience. I further comprehend that the information provided may be used to appease information requests of the regulators or in order to satisfy legal or regulatory requirements. I confirm that the information provided is true and correct and can be relied upon by Guardian Life and hereby grant permission for the usage of the information for the purposes herein stated or as may be required from an operational standpoint.

_____ _____ _____

NAME OF PROVIDER/APPLICANT **SIGNATURE OF PROVIDER/APPLICANT** **DATE**

FOR INTERNAL USE ONLY

Assigned Provider No.: | | | | | | ; | | | | | | ; | | | | | |

Application Approved By: _____ **Date:** _____

G U A R D I A N L I F E L I M I T E D – G U A R D I A N H E A L T H

12 Trafalgar Road, Kingston 5, Jamaica

Telephone: 876.978.4473 **Facsimile:** 876.927.4732 **Toll Free:** 1.888.633.3287

www.myguardiangroup.com

NOTE

1. For healthcare professionals, **EVIDENCE OF CURRENT REGISTRATION** with Medical, Dental, Pharmacy, Nursing Councils or any other body authorizing the applicant to practise in Jamaica IS REQUIRED.
2. For pharmacies, laboratories, diagnostic facilities and medical centres, we require **EVIDENCE OF REGISTRATION UNDER THE COMPANIES ACT INDICATING NAMES OF OWNERS.**
3. All provider locations must be in operation.
4. Please supply a certified English translation for any foreign language documentation.

REQUIREMENTS (Copies of documents must be certified by a Justice of the Peace)

MEDICAL	1. Current Annual Practising Certificate (issued by Medical Council)
SPECIALIST	1. Current Annual Practising Certificate (issued by Medical Council) 2. Academic Qualification of Specialty
DENTAL	1. Current Annual Dental Certificate (issued by Dental Council)
OPTICAL	1. Academic Qualification (from university) 2. Optometrist Registration
PHARMACY	1. Form E (Registration of Shop as a Pharmacy, issued by Pharmacy Council) 2. Form H (Current Registration of Pharmacist) 3. Ability to submit health insurance claims electronically
LABORATORY	1. Current Council of Professions Supplementary to Medicine Certificate (of the Medical Technologist) 2. Certification by the Ministry of Health's Standard & Regulations Department
RADIOLOGY	1. Current Council of Professions Supplementary to Medicine Certificate (of the Radiology Technologist) 2. Certification / Approval from Medical Physicist

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