Form PSSF
For Financial Hardship Applications

MEDICAL

Application to the Pension Commission for Approval of a Refund of Money from the Pension Fund under the Public Service Superannuation Act 1981 Based on Financial Hardship

Use this Application to apply to the Pension Commission for approval of a refund of money from the pension fund under the Public Service Superannuation Act 1981 based on financial hardship. Please read the Instructions before completing the Application. The Instructions tell you which Parts of the Application to complete.

YOU CANNOT USE THIS APPLICATION TO APPLY FOR A REFUND OF MONEY IF:

- **You are a pensioner.**
- **The money you seek to have refunded is not governed under the Public Service Superannuation Act 1981.**
- **You seek a refund for a category of financial hardship that is not permitted.**

YOU CANNOT APPLY FOR A REFUND OF MONEY FROM THE PENSION FUND FOR ANY CATEGORY OF FINANCIAL HARDSHIP UNTIL 5 YEARS AFTER THE DATE YOUR LAST APPLICATION WAS APPROVED. IF SUCCESSFUL, YOU CAN ONLY RECEIVE A REFUND OF UP TO A MAXIMUM OF 25% OF YOUR CONTRIBUTIONS WITH INTEREST AT THE TIME OF APPLICATION. PLEASE NOTE THAT THE ACTUAL AMOUNT APPROVED WILL BE BASED UPON THE AMOUNTS STATED IN INVOICES OR STATEMENTS SUBMITTED WITH THE APPLICATION, UP TO THE 25% MAXIMUM.

FURTHERMORE, YOU CAN ONLY RECEIVE REFUNDS FOR FINANCIAL HARDSHIP A MAXIMUM OF TWO TIMES DURING YOUR LIFETIME.

When you have completed the Application, send it along with the non-refundable application fee of $100 and any other required documents to the Pension Commission, P O Box HM 3384, Hamilton HM PX, Bermuda. You may also deliver the Application to the Pension Commission's office or email to info@pensioncommission.bm. **Do not send the Application to the Accountant General.**

A REFUND OF MONEY CAN ONLY BE APPROVED IF THE AMOUNT YOU ARE ABLE TO WITHDRAW IS AT LEAST $1,000.

THINK CAREFULLY BEFORE MAKING AN APPLICATION AS ANY REFUNDS WILL LIKELY RESULT IN A REDUCED PENSION AT RETIREMENT

Part 1
Information About the Applicant

1. Provide the following information about yourself: (please print)

Last Name	First Name	Middle Name(s)	Date of Birth (D/M/Y)
Mailing Address	Street Number and Name		Suite No.
City	Parish/Province/State	Country	Postal/Zip Code
(area code) Telephone Number (ext.)		(area code) Fax Number	

Part 1 continues on the next page.

Part 1 (continued)
Information About the Applicant

2. Have you attached a copy of the statement sent to you by the Accountant General showing your contributions with interest?

☐ **Yes**

☐ **No**

Document Required: You **must** attach a copy of the statement sent to you by the Accountant General. The statement must have been issued within 30 days before the date the Pension Commission receives it. You have a right to request in writing a statement from the Accountant General at no charge to you for the purpose of making an Application.

1. Only your contributions with interest in your pension fund under the Public Service Superannuation Act 1981 can be refunded using this Application. If you are unsure, ask the Pension Commission.

Was the money for which you are applying for, earned or contributed under the Public Service Superannuation Act 1981?

☐ **Yes**

☐ **No**

3. Are you employed? ☐ **Yes** ☐ **No**

4. Are you receiving a private pension payment? ☐ **Yes** ☐ **No**

Part 2B
Refund for Eligible Medical Expenses

Complete this Part **only** if you want a refund of money in respect of eligible medical expenses for you, your dependant or your parent. A refund **cannot** be received in respect of an eligible medical expense which has already been paid or which is due to be paid by a third party (e.g. the medical expenses claimed in this Part cannot have been paid or be payable through any medical insurance coverage (whether public or private)).

If you want to apply for eligible medical expenses for more than one person, you must get additional blank copies of this Part, complete a separate Part for each person and attach the additional completed Part(s) to this Application.

1. Have you ever received approval from the Pension Commission in the past for a refund of money under the Public Service Superannuation Act 1981?

☐ **Yes**

☐ **No**

If you answered "Yes", provide the date your last Application for a financial hardship refund was approved and the reference number assigned by the Pension Commission to that Application:

Date Your Application was approved (Day(/Month/Year)	Reference Number Assigned to the Application

You <u>cannot</u> apply again for financial hardship until 5 years after the date your last Application was approved.

2. How much money do you want to withdraw? (You can apply to withdraw up to 25% of your contributions with interest).

$ _____

You **cannot** withdraw more than the amount of the unpaid eligible medical expense as set out in the invoice or estimate. This amount will be paid directly to the provider of the medical or dental goods or services.

Additional Document(s) Required: You **must** attach a copy of the invoice or estimate from the medical or dental goods or services provider. Please **see page 10 of the Instructions** for more details. **You must also attach a completed Government of Bermuda new/change address form (from the Accountant General's Dept).**

3. Who has the illness or disability?

The person with the illness or disability **must** be one of the following:

☐ **Yourself** (please attach a copy of your government issued photo identification)

☐ **Your parent** (please attach a copy of their government issued photo identification)

☐ **A dependant (as defined - see page 6 of the Instructions)** (please attach a copy of your marriage certificate, or your sibling's or child's birth certificate)

Part 2B continues on the next page.

If you answered "Your parent" or "A dependant", provide the following information about your parent or dependant: (please print)

Parent/Dependant's Last Name	First Name	Middle Name(s)	Date of Birth (Day/Month/Year)
Parent's/Dependant's Mailing Address Street Number and Name	☐ Same as your Mailing Address, or:		Suite No.
City	Province/State Country		Postal/Zip Code
Parent's/Dependant's Telephone Number (area code) Telephone Number (ext.)	☐ Same as your Telephone Number, or:		

4. Describe the medical or dental goods or services that have been or will be purchased to treat the person's illness or disability: (please print)

Medical or Dental Goods or Services Purchased or to be Purchased (attach additional pages if necessary)

Additional Document(s) Required: You **must** attach a certification signed by a registered **Health Professional** (as defined in section 2 of the Bermuda Health Council Act 2004 or a person with qualifications accepted as equivalent by the Pension Commission) that the medical or dental goods or services are medically necessary. Please **see page 13 of the Instructions** for more details.

Part 3
Certification by the Applicant

You **must** sign this Application by completing and signing the Certification in this Part. **Please read the Instructions for completing the Certification found on page 13 of the Instructions before you complete the Certification.**

Certification

I participate in the pension fund identified in Part 1 of this Application. I hereby apply to the Pension Commission for approval for a refund for the amount set out in Part 2B of this Application.

I certify* that on the date I sign this Certification:

(a) I have no other reasonable way of raising money to pay the expenses or arrears;

(b) I have not been required by any third party to make this application;

(c) all of the information supplied in this Application and the documents that accompany this Application is accurate to the best of my belief; and

(d) If the application relates to expenses of my dependent or parent, to the best of my knowledge and belief, my dependent or parent (as the case may be) has no other way of raising money to pay the expenses.

I understand that if I do not provide information in this Application which is true, accurate and complete, the Pension Commission **will** refuse to give its approval.

Signature of Witness	Signature of Applicant	Date Signed (Day/Month/Year)
Name of Witness (print) Last Name	First Name & Middle Name(s)	**The Applicant must sign this Certification in the presence of the witness.**
Witness Address	Street Number and Name	**FOR HELP IN FILLING OUT THIS APPLICATION, CONTACT THE PENSION COMMISSION AT 441-295-8672**
City/Parish/Province/State	Country	* By signing, you are certifying that this statement is true.
(area code) Witness Telephone Number (ext.)	Postal/Zip Code	

Part 4
Authorization Regarding Personal Information

The Authorization in this Part **must** be signed by you. In addition, this Authorization **must also** be signed by every dependent over the age of 18 or parent identified in Part 2B of this Application.

Each person should read the Authorization and, if the person agrees to the terms set out in the Authorization, sign and date the Authorization in the appropriate place at the bottom of the Authorization. Please also fill in the name of any dependent (husband or wife, sibling or child) or parent that signs the Authorization. If any required person does not sign the Authorization as required, this Application **will not be complete.**

The Authorization will not be valid for the purposes of this Application if any required person signs the Authorization more than 30 days before the date the Pension Commission receives it.

The information in this Application is collected under the authority of the Public Service Superannuation Act 1981 (as amended).

Authorization

If this Application relates to a written demand for payment of arrears of rent, of unpaid mortgage or other payments relating to a debt secured against my or my husband's or wife's principal residence and I or my husband or wife have been threatened with imminent eviction from the rental home or loss of the principal residence, as applicable, I or my husband or wife (as applicable), authorize my or my husband's or wife's creditor to give the Pension Commission any information relating to my or my husband's or wife's arrears of rent or debts that are the subject of this application.

If this Application relates to eligible medical expenses to treat my, my dependent's or parent's illness or disability, I or my dependent or parent (as applicable), authorize my, my dependent's or parent's Health Professional or provider of the medical or dental goods or services, as the case may be, to give the Pension Commission any information relating to my, my dependent's or parent's illness or disability and the medical or dental goods or services that are the subject of this application.

If this Application relates to eligible educational expenses, I or my dependent (as applicable), authorize the relevant educational establishment to give the Pension Commission any information relating to the eligible educational expenses which are the subject of the claim for eligible educational fees.

I authorize my financial institution to give the Pension Commission any information relating to my financial records to confirm or verify any information provided by or about me in this Application.

I authorize any other person referred to in this Application to provide information to the Pension Commission with respect to this Application and the documents accompanying this Application, to assist the Pension Commission in understanding them and verifying their authenticity and to assist the Pension Commission in verifying the circumstances of financial hardship set out in this Application.

Signature of Applicant				Date Signed (Day/Month/Year)
Signature of Dependent/Parent (as applicable)	Dependent's/Parent's Last Name	First Name	Middle Name(s)	Date Signed (Day/Month/Year)
Signature of Dependent/Parent (as applicable)	Dependent's/Parent's Last Name	First Name	Middle Name(s)	Date Signed (Day/Month/Year)

Part 5
Certification of a Health Professional Regarding Treatment of an Illness or Disability

This Part must be completed if the Applicant has completed Part 2B of this Application. If completed, this Part qualifies as a certification signed by a Health Professional (as defined in section 2 of the Bermuda Health Council Act 2004 or a person with qualifications accepted as equivalent by the Pension Commission) regarding the medical or dental goods or services purchased to treat a person's illness or disability.

The Applicant cannot complete this Part.

If you are a Health Professional, in order for this Application to be considered by the Pension Commission you must complete the Certification below for the purposes of this Application. If you wish to complete the Certification, please check only one of the boxes in the Certification and fill in the other information needed to complete the top of the Certification. Read the completed Certification and if you are satisfied that the Certification correctly describes the situation of the person identified in Part 2B of this Application, then please sign, date and fill in the information at the bottom of the Certification.

The Health Professional Certification will not be valid for the purposes of this Application if the Certification is dated more than 3 months before the date the Pension Commission receives it.

Health Professional's Certification

I am a:
(Check only one of the boxes below.)

☐ physician licensed to practice medicine ☐ dentist licensed to practice dentistry

☐ other (please describe)

In my opinion,

_____

(Print the name of the person identified in Part 2B of this Application who has or had the illness or disability)

has an illness or disability and the following medical or dental goods or services are or were necessary for this person's treatment:

_____

_____

_____

_____

_____

(Print a description of the medical or dental goods or services identified in Part 2B of this Application that are or were necessary for this person's treatment. Attach additional pages if necessary.)

Health Professional Name (print)	Signature	Date Signed (Day/ Month/Year)
Address	Street Number and Name	Suite No.
City	Parish/Province	Postal Code
(area code) Telephone Number (ext.)		