OFFICE USE ONLY:

MoonGate Account #: _____

Policy Ref: _____

MOONGATE GROUP

SOFIA HOUSE, 48 CHURCH STREET, HAMILTON | HM FX, BERMUDA. TEL > 441 542 2200 | WWW.MOONGATEBDA.BM

MOONGATE EVACUATION SERVICES

Agent of Record Letter

HealthGap Supplement

Last Name: _____ First Name: _____ Middle Initial: _____

Unit/Apt Number: _____ Street:_____

Parish: _____ Postal Code: _____ Date of Birth (dd/mm/yy):_____

Email:_____

Home Phone: _____ Business Phone: _____

Emergency Contact Information

Last Name:_____ First Name: _____Middle Initial _____

Email: _____ _____

Home Phone: _____Mobile Phone: _____ Business Phone: _____

To Whom It May Concern:

This confirms that, as of the date listed below, I have appointed MoonGate Group to act on my behalf regarding my HealthGap Supplement. MoonGate Group will correspond with vendors to ensure discounted agreements are applied. The appointment of MoonGate Group shall remain in full force until the required one month's notice of cancellation is provided in writing.

Sincerely,

_____ _____

Client Signature Date

Current Health Plan: **Please check one**

ARGUS	BF&M	COLONIAL	HIP/FUTURECARE	GEH	NONE
☐	☐	☐	☐	☐	☐