Group Termination Form

CLEAR FORM

This form is to be used to terminate employees from the group's Health, Life and Disability policies.

Group policy name:	Group policy number:

Please check your most recent listing of employees which is on the back page of your premium invoice. If any of your employees have terminated their employment, please complete and return this form to BF&M. A maximum refund of one-month premium is allowed on any former employee.

Health certificate number	Life and Disability certificate number	Employee name (First/Middle/Last)	Health termination date (dd-mmm-yyyy)	Life and Disability termination date (dd-mmm-yyyy)

Declaration

Employer declaration and signature

I confirm that I have had the opportunity to review BF&M's privacy notice (www.bfm.bm/privacy) and have obtained the necessary consent (if required) from my employees to the processing of their personal information for the purposes described within the privacy notice.

Name:	Sign:	Date (dd-mmm-yyyy):

For BF&M official use only

Date processed: ____/____/____ Admin: _____ Comments: _____

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