Employee Health Insurance Change Request Form

CLEAR FORM

This form is to be used to update employee information, increase or decrease the employee's Health coverage, add, terminate or change dependents.

1. Type of change(s) requested

☐ Change employee information (Section 3) ☐ Change Health/Dental coverage (Section 4) ☐ Change of dependents (Section 5)

2. Current information

Group policy name:		
Employee name (as it appears on your card):		DOB (dd-mmm-yyyy):
Group policy #:	Health certificate #	Effective date of change (dd-mmm-yyyy):

3. Change employee information

Reason for change: ☐ Change contact information ☐ Name change (Supporting legal documents must accompany submission i.e. marriage, divorce, deed poll)

Title:	Name (First/Middle/Last):	
Address:		
Phone: H	W C	Email:

4. Change Health and/or Dental information

Clear Section

ⓘ **After two years, on the same plan, you may elect to increase/decrease your coverage by one medical and/or dental level. The date change must take effect on the 1st day of the month.**

Select your health coverage: ☐ Global Health ☐ Global Plus ☐ Global Elite ☐ Other:

Select your dental coverage: ☐ No Dental ☐ Basic Dental ☐ Comprehensive Dental

5. Change of dependents

Use this section to add/remove your child(ren), stepchild(ren), legally adopted child(ren), spouse or domestic partner as dependents.

Reason for change: ☐ Marriage/Divorce ☐ Adoption/Legal guardianship ☐ Birth ☐ Spouse employment change ☐ Students (18 years - 26 years) ☐ Other:

Health insurance dependents Use this section to add your child(ren), stepchild(ren), legally adopted child(ren), spouse or domestic partner as dependents.

ⓘ **Eligible child(ren) must be unmarried, 18 or younger or 18-26 years attending school, college/university as a full-time student. Please provide proof of full-time enrolment. Age limits do not apply to dependents with disabilities who are reliant on the insured for support and maintenance. Further paperwork may be requested as proof of eligibility and/or for underwriting requirements.**

Name (First/Middle/Last)	Action required (Add/Change/Terminate)	DOB (dd-mmm-yyyy)	Gender	Relationship to insured	Nationality

CLEAR PAGE

Dependent spouse information	Clear Section
Employment status: ☐ Unemployed ☐ Self-employed ☐ Employed	
Coverage required: ☐ Full (Standard Health and Supplemental Health benefits for non-working/self-employed spouse ☐ Supplemental only (Standard Health benefits c vered by spouse's employer)	
Previous insurance carrier:	Termination date (dd-mmm-yyyy):
Employee and dependents residents in Bermuda for at least 6 months out of the year? ☐ Yes ☐ No (Does not apply to overseas students that reside in Bermuda)	

Declaration

Employee declaration and signature:

I request BF&M Life Insurance Company Limited amend its records as indicated on this form. I authorise my employer to make any necessary adjustments to my required contribution, if any. I confirm that I have had the opportunity to review BF&M's privacy notice (www.bfm.bm/privacy) and I consent to the processing of my personal information for the purposes described within the privacy notice. If I have provided personal information relating to any third party, I confirm that I have received their consent for BF&M to process their personal information in line with the privacy notice.

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

Employer statement and signature:

I confirm that I have verified the identity of this member and to the best of my knowledge that the information provided by the member is accurate.

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

For BF&M official use only

Coverage level from: _____ to: _____ Date processed: ____/____/____ Admin: _____