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. Please print.

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

Clear Section

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

Clear Section

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

Name (first/middle/last):

Address:

Phone: H W C Email:

4. Change Health and/or Dental coverage

Clear Section

ⓘ **After 2 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 ☐ SHB* ☐ Other:

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

** Standard Health Benefits (Only employees can enroll for SHB coverage. Dependents are not eligible.)*

5. Change of dependents

Clear Section

ⓘ **Use this section to add/remove 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.**

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

Health insurance dependents

Name (first/middle/last)	Action required (add/change/terminate)	DOB (dd-mmm-yyyy)	Gender	Relation to insured	Nationality

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5. Change of dependents (cont'd)

Clear Section

Dependent spouse information	
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 covered by spouse's employer)
Previous insurance carrier:	Termination date (dd-mmm-yyyy):

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 Policy (www.bfm.bm/privacy) and I consent to the processing of my personal information for the purposes described within the Privacy Policy. 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 Policy.

Employee name:	
Sign:	Date (dd-mmm-yyyy):

Employer declaration and signature (authorised signatory):

I confirm that I have all necessary consents and notices in place to enable the lawful transfer of employees' personal data to BF&M for the purposes described in BF&M's Privacy Policy (www.bfm.bm/privacy). I confirm that I have verified the identity and details of this member from section 2, of this form, and that the information provided is accurate.

Signatory name:	
Sign:	Date (dd-mmm-yyyy):

For BF&M official use only

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