



Employee Health Insurance Change Request 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

Group policy name: <input type="text"/>		
Employee name (as it appears on your card): <input type="text"/>	DOB (dd-mmm-yyyy): <input type="text"/>	
Group policy #: <input type="text"/>	Health certificate #: <input type="text"/>	Effective date of change (dd-mmm-yyyy): <input type="text"/>

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

i 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

i 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
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

5. Change of dependents (cont'd)

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

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.

Name: <input type="text"/>	
Sign: <input type="text"/>	Date (dd-mmm-yyyy): <input type="text"/>

Employer declaration and signature:

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 of this member and to the best of my knowledge the information provided by the member is accurate.

Name: <input type="text"/>	
Sign: <input type="text"/>	Date (dd-mmm-yyyy): <input type="text"/>

For BF&M official use only

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