Group Health, Life and Disability Benefits Enrolment Form

CLEAR FORM

Employer completes section 1. Employee completes section 2, 3 and 4. Employee and employer signatures are required on page 2.

1. Group employer information To be completed by the employer

Group policy name:	Group policy number:
Policies available: ☐ Health insurance ☐ Life insurance ☐ Long Term Disability insurance ☐ Short Term Disability insurance	
Hours worked per month (Health benefits):	Hours worked per week (Life and Disability benefits):
Date employed (dd-mmm-yyyy):	Annual salary (Life and Disability only): BMD$/USD$
Health enrolment date (dd-mmm-yyyy):	Life and Disability enrolment date (dd-mmm-yyyy):

2. Employee information To be completed by the employee

Title:	Name (First/Middle/Last):	Gender: ☐ Male ☐ Female
DOB (dd-mmm-yyyy):	Nationality:	Occupation:
Address:		
Phone: H	W	C / Email:

3. Health and Dental benefits To be completed by the employee

ⓘ **You must remain on the chosen health/dental plan for two years. You may switch up or down one plan level without medical underwriting upon completing the two-year period.**

Person(s) to be insured: ☐ Self ☐ Spouse/Domestic partner ☐ Children (18 years or younger) ☐ Students (18 years - 26 years)	
Have you been insured with BF&M during the past 31 days? ☐ Yes ☐ No	Previous employer:
Select your health coverage: ☐ Global Health ☐ Global Plus ☐ Global Elite ☐ Other:	
Select your dental coverage: ☐ No Dental ☐ Basic ☐ Comprehensive	

Health insurance dependents Complete 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 or university as a full-time student. Age limits do not apply to dependents with disabilities who are reliant on the insured for support and maintenance.**

Name (First/Middle/Last)	DOB (dd-mmm-yyyy)	Gender	Relationship to insured	Nationality

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):
Employee and dependents resident in Bermuda for at least 6 months out of the year? ☐ Yes ☐ No (Does not apply to overseas students that reside in Bermuda)	

Dependent child school information

ⓘ **Complete this section for all children 18-26 years attending school, college or university as a full-time student. Attach school receipts to verify current enrolment.**

Dependent child name (First/Middle/Last)	School, college or university name	Location

4. Life insurance benefits

Please complete this section if you are eligible to be enrolled in Life (LF) Insurance benefits

Clear Section

Beneficiaries

ⓘ **The person(s) or entity(ies) designated as a primary beneficiary is first in line to inherit your life insurance benefit when you pass away. Benefits are only payable if the group and/or employee policy is active when submitting the claim. If more than one primary beneficiary is named, the beneficiaries share the inheritance when you die. If one or more of the primary beneficiaries do not take their share of the inheritance, it will be split equally between any remaining primary beneficiaries.**

The contingent beneficiary is the person(s) who becomes the beneficiary(ies) if the primary beneficiary(ies) dies or is otherwise disqualified. Contingent beneficiaries inherit only if none of the primary beneficiaries can be located, if they refuse the inheritance or if they die before you do. In other words, contingent beneficiaries will be second in line behind your primary beneficiaries and inherit nothing as long as one of your primary beneficiaries accepts their inheritance.

I hereby appoint the following beneficiaries to receive any amount due under this policy upon my death.

Beneficiary name (First/Middle/Last)	Nationality	DOB (dd-mmm-yyyy)	Relationship	Share % Primary	Share % Contingent
				☐ %	☐ %
				☐ %	☐ %
				☐ %	☐ %
				☐ %	☐ %
				☐ %	☐ %
ⓘ **The total share % for all primary beneficiaries and contingent beneficiaries must add to 100%.**			Total share %:		

Trustees

ⓘ **A Trustee must be named if any beneficiary(ies) is under the age of 18.**

Trustee name (First/Middle/Last)	Nationality	DOB (dd-mmm-yyyy)	Relationship to beneficiary

Declaration

Employee declaration and signature:

I confirm that I am applying for benefits that are available through the group policy provided by my employer and that the information provided is factual and true. 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.

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

Employer statement and signature:

I confirm that I have verified the identity of this member and details provided in Section 1 of this form. I confirm to the best of my knowledge that the information provided by the member is accurate.

Employer name:	Sign: _____	Date (dd-mmm-yyyy):

For BF&M official use only

Policy #: _____ HL cert #: _____ Category: _____ HL date: ____/____/____

NHL cert #: _____ Prob. period: _____ LF: ___ ADD: ___ LTD: ___ WI: ___ NHL date: ____/____/____ Admin: _____