GOVERNMENT OF BERMUDA
Ministry of Finance

Department of Social Insurance

CONTRIBUTORY PENSION/GRATUITY APPLICATION FORM

Please use BLOCK **CAPITALS** when filling out this form.
BE SURE TO ANSWER ALL QUESTIONS

When completed, this form should be taken or sent to:

DEPARTMENT OF SOCIAL INSURANCE
Ground Floor
Government Administration Building
30 Parliament Street, Hamilton HM 12
Bermuda

OFFICIAL USE
Social Insurance No.:
Claim No.:
Received By:
Date of Receipt/Stamp:
Approved/Disapproved By and Date:
Birth Cert/Passport No:
Verified By:

AN APPLICATION SHOULD BE MADE WITHIN 13 WEEKS FROM THE DATE A PERSON BECOMES ELIGIBLE FOR THE BENEFIT. DELAY IN CLAIMING MAY RESULT IN LOSS OF BENEFIT.

CONTRIBUTORY PENSIONS ACT, 1970
A person shall be entitled to a contributory old age pension if he/she-

- is over pension age (over age 65); **and**
- satisfies the relevant contribution conditions

PARTICULARS OF CLAIMANT

1.					
SURNAME	FIRST NAME	MIDDLE NAMES	MR. MRS. MISS (CIRCLE)		
2. Maiden Name (or other surname at date of birth)					
3. Permanent Address					
Mailing Address (if different from above)					
Telephone Number(s)					
Email Address					
Please check this box if you would like to receive an email confirming receipt of application ☐					
4. Date and place of birth. Please submit a **certified copy of your birth certificate and photo ID or valid passport** with this form.					
	Day	Month	Year	Place	
4a. UK National Insurance No:(If applicable)					
5. Bank Name (All applications must be submitted with proof of banking details. i.e. copy of bank statement, void check etc.)					
Account Number					
IBAN Number/Routing Number (If applicable)					
Sort Code (If applicable)					

6. Are you in any receipt of any Social Insurance benefit?	Yes or No (Circle One)
6a. If yes, what type of benefit	
7. Date of last employment (In Bermuda)	Day Month Year Place
8. If you are a retired person, please state the date on which you ceased to be gainfully employed	Day Month Year Place

Below, please list Employment History

Employer	Time Period (e.g. 2001-2017)	Part Time or Full Time

9. Name of Spouse	
9a. Spouse's Social Insurance number	
9b. Spouse's Date of Birth	Day Month Year Place

DECLARATION
(WARNING: Giving false information may result in prosecution.)

I ________________________________ declare that to the best of my knowledge and belief all the statements on this form are true.	**WITNESS TO SIGNATURE** The signature opposite was made or acknowledged by the applicant in my presence. Print Name: _________________________________ Signature: ___________________________________
(Application's usual signature or mark if unable to write)	Address: ____________________________________
Date:	**Date:**
	(The Applicant's signature must be witnessed by a householder who is not a relative or by an officer of the Department of Social Insurance.)

Please note that an incomplete application may result in a delayed pension payment. All sections of this application MUST be completed in order for processing to begin. Processing takes 30 to 60 days. To query an application, please call 294 9242 ext 1129 or email sibenefits@gov.bm