DEPARTMENT OF SOCIAL INSURANCE

EMPLOYER #.……

EMPLOYER NAME: ……

ADDRESS: ……..

TELEPHONE……..

EMAIL ADDRESS. ……

EMPLOYEE SUSPENSION FORM
(Employers Only)

P. O. Box HM 1537, Hamilton HM FX
Telephone: 444-2470
SIsuspend@gov.bm
www.gov.bm

FULL NAME OF EMPLOYEE (Surname First)	**Date of Birth Day/Mth/Yr**	**Social Insurance Number**	**Suspension Start Date Day/Mth/Yr**

USE THIS FORM FOR EMPLOYEE CONTRIBUTION SUSPENSIONS ONLY

Authorized Signature……. Date ……

Name of Authorized Signatory…….
(Print in block capitals)