Health Insurance Department

Provider Compliance Verification

FOR OFFICIAL USE

☐ New Provider

☐ Annual Compliance Check

Group Practice Information:

Name of Company

Principal(s) and/or Director(s) of the Company (enter names below):

First Name	Middle I	Last Name

Mailing Address:

Parish: Postal Code:

Email: _____

Website: _____

Please attach proof of the following:

Bermuda Payroll Tax No.: . _____

Bermuda Social Insurance No.: _____

Company Health Insurer: _____

Personal Pension Provider: _____

We confirm that we, the undersigned, are conducting business as a proper legal entity in Bermuda and are not delinquent in making payments for Government receivables such as Social Insurance contributions, Payroll Tax and Public Works (formerly Works & Engineering) fees.

Dated this _____ day of _____, 20_____

(Print Name) _____

(Signature) _____