Health Insurance Department
Health Insurance Plan / FutureCare Plan
Policy Cancellation / Plan Transfer Form

FOR OFFICIAL USE

Effective Date (dd/mm/yy): _____

Processed By and Date (dd/mm/yy): _____

Policyholder Details (Please Print)……

Name: **(Mr./Mrs./Miss/Ms.)** **(First Name)**

(Middle Name) **(Last Name)**

Mailing Address:

Parish: Postal Code:

Policy Number: Group Number:

Date of Birth (dd/mm/yy): / / Telephone Number: --

Email Address: _____

Requesting: ☐ Policy Cancellation ☐ Plan Transfer

Policy Cancellation Details *(to be completed for Policy Cancellation request)*

☐ Policyholder Deceased — Date of Death (dd/mm/yy): / /
(Please attach copy of Death Certificate, Obituary or Memorial notice)

Power of Attorney / Next of Kin — Tel No: --

Name:

Address:

Parish: Postal Code:

☐ Terminated Employment — Last Day of Work (dd/mm/yy): / /

☐ No Longer a Bermudian Resident — Date of Departure (dd/mm/yy): / /

☐ Other Insurance Coverage in Force — Name of Insurer: _____

Effective Date (dd/mm/yy): / /

☐ Unable to pay — Cancellation Date (dd/mm/yy): / /

☐ Other — Cancellation Date (dd/mm/yy): / /

Plan Transfer Details *(to be completed for Plan Transfer request. Enrolment Form to be completed and attached.)*

Plan transferring **from**: ☐ HIP ☐ FutureCare || Plan transferring **to**: ☐ HIP ☐ FutureCare

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I declare that the information above is accurate to the best of my knowledge.

Signed: _____ Date (dd/mm/yy): / /

Mailing Address: Health Insurance Department, P.O. Box HM 2160, Hamilton HM JX
Street Address: Sofia House, 2nd Floor, 48 Church Street, Hamilton HM 12
Phone: 441-295-9210 **Fax:** 441-295-9213 **Website:** www.hip.gov.bm **Email:** hip@gov.bm