Health Insurance Department
Health Insurance Plan / FutureCare Plan
Policyholder Information Change Request

FOR OFFICIAL USE ONLY:

Processed by CSR and Date (d/m/y): _____

*Approved by and Date (d/m/y): _____

*** Supporting documentation and approval are required for a Name Change, Date of Birth correction or request to address cheques to individuals other than the name listed on the account**

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

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

Policy Number: Group Number (if applicable):

Policyholder's New Information (*if changed*)

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

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

Mailing Address:

Parish: Postal Code:

Policy Number:

Date of Birth (dd/mm/yy): / /

Telephone Number: _____
(Home) (Work) (Other)

Email Address: _____
(Please Print)

Supporting Documentation (Please check appropriate box):

☐ Birth Certificate ☐ Marriage Certificate ☐ Driver's License

☐ Power of Attorney ☐ Other _____
(Please describe)

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

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

When completed, this form should be returned with supporting documentation to:
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