ADDITION / DELETION OF DEPENDANTS TO G.E.H.I. MEDICAL AND DENTAL INSURANCE

Please ensure that your payroll administrator has a copy of your completed form.

DEPARTMENT: _____

G.E.H.I. #: _____   **NAME:** _____

                                                      First   Middle   Last

Please **ADD** / **DELETE** the following dependent(s) to my G.E.H.I. policy with effect from: __ __ / __ __ __ / __ __ __ __
(circle add or delete)   D ay   Month   Year

| Last Name | First Name | Middle Initial | Date of Birth | | | Sex (M / F) | Relationship to you | school child(ren) attend unemployed Spouse employer | Medical Benefits | | | ****Dental Benefits**** | |
			Day	Month	Year				Full Public	Full Semi-Private	Fringe	Basic	Comprehensive

****Your dependant(s) dental coverage has to be the same as your dental coverage. Example: If you have basic dental coverage than your dependent(s) must have basic dental coverage.****

Please read the following notes carefully, then sign and date.

1. Fringe medical benefits means non-hospital benefits. Spouses employed with standard hospital coverage can join GEHI for fringe coverage only.

2. Semi-private is not necessary for children who are entitled to youth subsidy, as Government covers the local cost of hospital care (at the public ward level) for children under the school leaving age and up to 21 if in full-time school in Bermuda.

3. Unemployed spouses must by law be enrolled.

4. A newborn baby must be added to GEHI within 1 month of their date of birth to avoid a waiting period for enrolment. After that time there will be a 6 month waiting period before the newborn can join GEHI.

5. Dependant children can remain on GEHI if they are still being educated up until age 26.

DECLARATION

I understand that premiums for medical benefits requested will be deducted in advance and dental benefits deducted current from my wage / salary. I undertake to report immediately any change to my spouses employment, the school my child(ren) attend(s) and when my child(ren) turn(s) 26 years old.

Employee Siganture: _____   Date: ____ / ____ / ____
                                                                                             D   M   Y