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):	

	oproval are required for a Name Change, Date of Birth	
Name: (Mr./Mrs./Miss/Ms.) (First Name) (Middle Name)	es to individuals other than the name listed on the account (Last Name)	
Policy Number: Group Number (if applicable):		
Policyholder's New Information (if changed) Name: (Mr./Mrs./Miss/Ms.) (First Name)		
	(Last Name)	
Mailing Address:		
Parish: Postal Code: 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