Health Health	alth Insurance Department Insurance Plan / FutureCare Plan Ider Information Change Reques	
	mentation and approval are required to address cheques to individuals of	d for a Name Change, Date of Birth ther than the name listed on the account
Name: Mr./Mrs./Miss/Ms.)		
(Middle Name) Policy Number:	(Last N Group Number (if a	
Policyholder's New Informat	ion ( <i>if changed</i> )	
Name: Mr./Mrs./Miss/Ms.)		
(Middle Name) Mailing Address:	(Last N	
Parish:	Postal	I Code:
Policy Number:		
Date of Birth (dd/mm/yy):		
Telephone Number:	(Home) (Wo	ork) (Other)
Email Address:		
	(Please Prir	nt)
Supporting Documentation	(Please check appropriate box):	
Birth Certificate	□ Marriage Certifica	ate 🛛 Driver's License
□ Power of Attorney	□ Other	(Please describe)
I declare that the information	n I have given above is accurate to t	he best of my knowledge.
	Dat	te (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: <a href="https://www.hip.gov.bm">www.hip.gov.bm</a> Email: hip@gov.bm</a>