COLONIAL MEDICAL INSURANCE COMPANY LIMITED

Employee Change Request

To be completed by the employer for any additional employees and/or dependents, terminated employees or removed dependents or to detail any changes to employee information. Please complete, sign and send to fax no. 441-295-9036 or email to Kristin.Gibbons@colonial.bm or Ehbony.Parsons@colonial.bm.

Group Name: _____ Group No.: _____

Employee (Emp) Name	**Cert. No.**	**Add*** Emp Dep	**Delete**** Emp Dep	**Amend** Emp Dep	**Effective Date** dd/mm/yy	**Dependent (Dep) Full Name**	**Relation*****	**New Salary**
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Other:								

Signature: _____ Print Name: _____ Date: _____

*Must be accompanied by a fully-completed Enrolment Card **Please return all issued Insurance ID Cards *** If adding a working spouse, please name their employer