

DEPARTMENT OF SOCIAL INSURANCE



EMPLOYER #.....

EMPLOYER NAME:

ADDRESS:

TELEPHONE.....

EMAIL ADDRESS.

EMPLOYEE ADJUSTMENT FORM

P. O. Box HM 1537, Hamilton HM FX
Telephone: 294-9242 Press 3
sicontributions@gov.bm
www.gov.bm

FULL NAME OF EMPLOYEE (Surname First)	Date of Birth Day/Mth/Yr	Insurance Number	Start Date Day/Mth/Yr	Termination Date Day/Mth/Yr	Unpaid Leave <i>from</i> Date Day/Mth/Yr	Unpaid Leave <i>to</i> Date Day/Mth/Yr	Number of Contributions (Weeks) on Unpaid Leave

USE THIS FORM FOR ALL EMPLOYEE ADJUSTMENTS

PLEASE SUBMIT WORK PERMITS
FOR ALL WORK PERMIT HOLDERS

Authorized Signature..... Date

Name of Authorized Signatory
(in block capitals)