



GOVERNMENT OF BERMUDA

Ministry of Finance

Department of Social Insurance
CUSTOMER REFUND REQUEST FORM

Employer Account Name _____

Employer Account Number _____

Refund Request: ☐ Over Paid ☐ Account Closed
☐ Owner Deceased ☐ Other (*specify*) _____

Refund Amount: _____

(You must submit relevant documentation to support the refund i.e. an Invoice and Bank Statement)

BANK DETAILS		
Bank		
Account Name		
Account Number		
Payee's Address		
Payee's Phone		
Payee's email		
Payee's Signature	Print Name	Date

Official Use Only		
☐ Approved ☐ Rejected		
Comments:		
Payment Details		
Refunded Amount: Date Processed:		
Officer's Signature	Print Name	Date
Manager's Signature	Print Name	Date