



GOVERNMENT OF BERMUDA
Ministry of Finance

Department of Social Insurance
SURVIVORS BENEFIT APPLICATION FORM

Please use BLOCK **CAPITALS** when filling out this form.
BE SURE TO ANSWER ALL QUESTIONS

When completed, this form should be taken or sent to:

DEPARTMENT OF SOCIAL INSURANCE
Ground Floor
Government Administration Building
30 Parliament Street, Hamilton HM 12
Bermuda

OFFICIAL USE
Social Insurance No.:
Claim No.:
Received By:
Date of Receipt/Stamp:
Approved/Disapproved By and Date:
Birth Cert/Passport No:
Marriage Cert No:
Death Cert No:
Verified By:

AN APPLICATION SHOULD BE MADE WITHIN 13 WEEKS FROM THE DATE A PERSON BECOMES ELIGIBLE FOR THE BENEFIT. DELAY IN CLAIMING MAY RESULT IN LOSS OF BENEFIT.

CONTRIBUTORY PENSIONS ACT, 1970

A person shall be entitled to a **Survivors Benefit** if he/she-

- A widow/widower, shall be entitled to an allowance, if the deceased at the date of death satisfies the relevant contribution conditions.
- A widow/widower, shall be entitled to a widow’s gratuity if the deceased at the date of death failed to satisfy the relevant contribution conditions.
- The child/children shall be entitled to an Other Gratuity in the absence of a widow/widower.
- The estate representative shall be entitled to a benefit in the absence of a widow/widower or children.

PARTICULARS OF CLAIMANT

1.	SURNAME	FIRST NAME	MIDDLE NAMES	MR. MRS. MISS (CIRCLE ONE)
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2. Maiden Name (or other surname at date of birth)

3. Permanent Address

Mailing Address (if different from above

Telephone Number(s)

Email Address

4. Date and place of birth. Please submit a **certified copy of your birth certificate and photo ID or valid passport** with this form.

Day	Month	Year	Place
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4a. UK Insurance No:(If applicable)

5. Bank Name

Account Number

IBAN Number/Routing Number (If applicable)

Sort Code (If applicable)

6. Date and place of marriage Please submit documentary evidence (If applicable)	Day	Month	Year	Place
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PARTICULARS OF DECEASED

7. (a) Surname	
(b) First and other names	
(c) Date of birth	Day Month Year Place
(d) Date and place of death. Please submit documentary evidence.	Day Month Year Place
8. Was he/she receiving a contributory pension at the date of death? If yes, please state social insurance number.	Yes ☐ or No ☐
9. Name and address of deceased’s last employer	

PARTICULARS OF CHILD(REN) UNDER SCHOOL LEAVING AGE (18 YEARS OF AGE)				
Surname	Other Names	Date of Birth (Submit documentary evidence)	Is the child living with you?	Is the child wholly or mainly maintained by you?

If the child has been legally adopted, please provide the adoption certificate.

DECLARATION (WARNING: Giving False information may result in prosecution.)	
I _____ DECLARE that I am the widow/widower, legal guardian, or Estate Representative, and that the information given on this form is true to the best of my knowledge.	WITNESS TO SIGNATURE The signature opposite was made or acknowledged by the claimant in my presence.
(Claimants usual signature or mark if unable to write)	Signature: _____ Address: _____
Date: _____	Print Name: _____
IMPORTANT The applicant, In addition to signing the above Declaration should sign again in the space to the right. —————→ This additional signature is required for record purposes.	The Claimant’s signature must be witnessed by a house-holder (not a relative) or by an officer of the Department of Social Insurance. USUAL SIGNATURE OF CLAIMANT TO BE WRITTEN BELOW. DO NOT USE BLOCK CAPITALS. MUST BE WRITTEN IN INK. _____ Claim No: _____