CG | ATLANTIC MEDICAL & LIFE

INFORMATION CHANGE REQUEST

Premier Health

PART 1 EMPLOYEE'S DETAILS

Surname _____ First Name _____ Middle Initial(s) _____

Address _____

Contact Nos _____ Email _____

Group Name/No. _____ Certificate No. _____

Position/Job Title _____ Date of Birth (DD/MM/YY) _____

☐ Male ☐ Female Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

PART 2 TYPE OF CHANGE REQUESTED (please tick all that apply)

1. ☐ Change coverage to: ☐ Member only ☐ Member & Spouse ☐ Member & Child ☐ Member & Children ☐ Family
2. ☐ Add a Dependent (Please provide details in the chart below. An Enrolment Form with Dependents details fully completed is also required.)

   If adding a spouse, please attach a copy of Marriage Certificate and give date of marriage (DD/MM/YY) _____

   If adding an adopted child, please attach a copy of the Adoption Certificate and give date of adoption _____

   If adding a child with a different last name, please include a copy of their Birth Certificate.
3. ☐ Remove a Dependent (Please provide details in the chart below.)

   If removing a family member, give reason and effective date: _____

Added/Removed Dependent(s) (Surname, First Name, Initials)	Date of Birth (DD/MM/YY)	Relationship

4. ☐ Change address to address noted in Section I.
5. ☐ Change name from _____ to name noted above.
   (Please attach supporting documentation proving name change.)

PART 3 SIGNATURES

Signature of Employee _____ Date _____

Signature of Employer _____ Date _____

FOR OFFICE USE	Service Code:	Effective Date of Coverage:

Atlantic Medical Insurance Limited
Atlantic House, 2nd Terrace & Collins Avenue | PO Box SS-5915, Nassau, Bahamas | Tel 242 326 8191 | Fax 242 326 8189
Suite 7-8, Jasmine Corporate Center | PO Box F-42655, Freeport, Bahamas | Tel 242 351 3960 | Fax 242 351 7442 | www.CGCoralisle.com

Health Insurance and Employee Benefits

INSURANCE | HEALTH | PENSIONS | LIFE

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