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)

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

4a. UK Insurance No:(If applicable)

5. Bank Name

Account Number

IBAN Number/Routing Number (If applicable)

Sort Code (If applicable)

Updated January 2016

6. Date and place of marriage
   Please submit documentary evidence (If applicable)

Day	Month	Year	Place

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? Yes or No
   If yes, please state social insurance number.
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.

(Claimants usual signature or mark if unable to write)

Date:

WITNESS TO SIGNATURE
The signature opposite was made or acknowledged by the claimant in my presence.

Signature:____
Address:

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: ______________________________________