



GOVERNMENT OF BERMUDA

NEW HIRE / PERSONAL DATA / OTHER CHANGES FORM

New Hire: Permanent: Promotion: Secondment: Transfer:
Re-Appointment: Demotion: Extension: Temporary: Other Change:

SECTION A: EMPLOYEE PERSONAL INFORMATION (TO BE COMPLETED BY EMPLOYEE)

Employee Number:
Employee Name: Last Name First Name Middle Name(s)
Maiden Name:
Date of Birth (dd/mm/yr):
Nationality: Bermudian Other (specify):
Spouse of a Bermudian? Yes No
Prior Gov't/Quango Employee: Yes No
Previous Dept/Quango:
Last Service Date (dd/mm/yr): Employee in receipt of Government pension: Yes No
Address Line 1: City:
Address Line 2: Postal Code:
Address Line 3: Country:
Phone No: (H) (W) (C)
Email Address:
Social Insurance No.: Ethnicity:
Gender: M F Marital Status: Single Married Divorced Widow(er) Date:
Bank Name: Account No.:
Type of Account: Savings Checking
In case of Emergency, please contact: Relationship:
Phone No: (H) (W) (C)

EMPLOYEE SIGNATURE: DATE:

SECTION B: TO BE COMPLETED BY PR/HR ADMINISTRATOR

Date Started (dd/mm/yr): Date of Original Employment (dd/mm/yr):
Date in Position (dd/mm/yr):
Increment Date (dd/mm/yr): 2nd Increment Date: (BIU)
Start Superannuation Date (dd/mm/yr): (must be 18yrs old; optional for age 57 and over)
Contract End or Termination Date (dd/mm/yr): (if applicable)

SECTION C: POSITION DETAILS

Home Company: Security Business Unit:
Home Business Unit: Check Route Location:
Supervisor: Work Unit (W&E only):
Position ID No.: Position Title:
Position Status: Temporary Permanent Job Type:
Negotiating Body: Benefit Group:
Position Pay Grade Range: From To Hourly Weekly Rate:
Pay Frequency: Monthly Weekly
Labour Distribution (if different from Home Business Unit):

SECTION D: EMPLOYEE PAY AND STANDARD HOURS DETAILS

Annual Salary: Pro-Rated Salary (Education only):
Hourly Rate: Hourly Premium Rate:
STD Hours Per Week: STD Hours Per Year:
Employment Status: Full-Time Part Time
Employee Pay Grade Range: From To Employee Pay Point:

SECTION E: OTHER INFORMATION

Eligible for Exemption from Social Insurance: Yes No If no, explain
Does this employee require GEHI? Yes No If no, explain
Contract Worker: Yes No Work Permit End Date (dd/mm/yr):
(Work permit holder only) (Should be same as contract end date)
Employee Subject to Probation: Yes No
Period of Probation: 3 months 6 months 1 year 2 years 3 years Not applicable
Permanent Resident Certificate Holder (PRC Holder): Yes No
Badge Number: (if applicable)

Remarks

PR/HR Administrator Signature: Date:
HOD Authorized Signature: Date:

**NEW HIRE / PERSONAL DATA / OTHER CHANGES
INSTRUCTIONS FOR COMPLETING THE FORM**

To be completed by the employing department. All sections are to be completed

Purpose of form

1. Check the box next to the option for the purpose of completing the form (i.e. New Hire, Promotion, Transfer etc.)
 - a. **New Hire** – Used to setup new employees on payroll
 - b. **Permanent** – Moving employees from relief posts to permanent posts
 - c. **Promotion** – Moving to a post of a higher pay grade
 - d. **Secondment** – Temporary job assignment (Position ID does not change)
 - e. **Transfer** – Moving from one post to another on the same pay grade
 - f. **Re-appointment** – Used to reappoint an employee to another contract (i.e. when employee completes the term of a contract and is given another contract)
 - g. **Demotion** – Moving to a post of a lower grade and paid at the new grade
 - h. **Extension** – Extending an existing contract for a short period of time (i.e. 6 months or less until the post has been filled)
 - i. **Temporary** – Used to setup a new employee for an approved period
 - j. **Other Change** – Used for home business unit and position ID changes or increment date change

Section A

1. Insert the employee number if the employee has worked for Government previously
2. If the employee was previously employed with Government/Quango, check Yes or No and state the Department or Quango
3. Last service date is the date the employee ended his/her employment with the previous Department or Quango. If unknown, the information must be researched in the system.
4. Social Insurance number is mandatory for ALL new employees over the age of 18 years
5. Ethnicity – if employee does not insert this information, refer to 'CURE' form completed when interviewed. If employee was not interviewed, leave blank.

Section B

1. Date of Original Employment is the date the employee first started a period of employment for the Government of Bermuda. If it is for a new employee the Date of Original Employment will be the same as the Date Started.
2. Date in Position is the start date in a post due to: items in section 1 a-e and h
3. Increment date is normally the anniversary date from the date started to move to the next pay grade. Review relevant Union Agreement Booklet.
4. Superannuation date is the date to commence pension deductions. Usually is the start date of employment in a substantive or temporary additional post. If the employee is in a temporary relief post for more than 6 consecutive months then the superannuation date will be 6 months from the date started.
5. Contract end or termination date is the last day of service of a contract or temporary assignment.

Section C

1. Home Company is the Department head number
2. Security Business Unit is the same as the home business unit (formerly Home Cost Centre number)
3. The home business unit is where the budget provisions for this position have been allocated in the current fiscal year Budget Book. This is where the salary will be charged in the Financial Accounts unless the Labour Distribution field is completed.
4. Cheque Route Location – location to where the cheque or pay advice is to be sent if different from the Home Business Unit.
5. Supervisor is where you enter the employee's supervisors' employee number.
6. The Position ID No is the number allocated by Department Human Resources (DHR) to the position. **Only one employee** can be employed against a Position ID number at a time.
7. Job type is the number provided by DHR when requesting a position ID number
8. Negotiating Body – select the appropriate union stated in the contract: ASP, BIU, BPSU, BUT, FSA, LEGCO, MISC, PA, POA, REG, MP, P, CONS and QUANGO
9. Benefit group – ASP, BIU/M, BIU/W, BPSU/M, BPSU/W, BUT/M, BUT/W, CONS, FSA, LEGCO, MISC/M, MISC/W, PA, PAYOFF, PENS, POA, POA/W and QUANGO
10. Pay Grade Range – applies to PS Step for monthly paid employees. Hourly/Weekly Rate applies to weekly paid employees.
11. Labour distribution is the account the salary or wage is withdrawn from if different from the home business unit

Section D - Pay and Standard Hours are found in the relevant Union Agreement Booklet

1. Standard Hours per Week are normally: 35 hrs, 37.5 hrs, 40 hrs and 42 hrs.
2. Standard Hours per Year are: BUT – 1400 hrs, ASP – 1470 hrs, BPSU – 1820 hrs, BIU – 1950 hrs, PA, POA, LEGCO, MP – 2080 hrs, FSA – 2184 hrs and REG – 2288 hrs.
3. Employee Pay Point is the pay point the employee is to be placed on

Section E

1. Eligibility for exemption from Social Insurance deductions is normally given to full-time students and employees approved to work beyond 65 years of age. Contact the Department of Social Insurance for more details.
2. GEHI is mandatory for all employees unless the employee is a full-time student or part-time employee employed for less than 3 months. Contact the benefits section (acgbenefits@gov.bm) of the Accountant General's Department for more details
3. Work permit end date is the expiration date on the work permit which should also match the contract end date
4. Badge number is for identification purposes i.e. Police, Corrections, Fire and Customs Officers
5. Remarks is used to insert any other information not covered on the form (i.e. any specific instructions for the employee), to record employees PID and home business unit if moving to another post or secondment instructions, etc.

**NEW/CHANGE ADDRESS FORM
GOVERNMENT OF BERMUDA**

APPLICANT DATA
Please print in CAPITAL LETTERS and use BLACK OR BLUE INK
Applicant: Individual Business

First Name:
Middle Name:
Last Name:
Trading Name:
Legal Entity Name: (If Different)

Company Tax ID/ Registration Number:
Social Insurance Number:
Employee Number:
Business/ Home Address (include Postal Code)

Mailing Address (if different from above)

Phone Number: (include area code)

Alternate Cellular Phone (include area code)

E-Mail Address:
SIC Code: (Category Code 1)

IDENTIFICATION INFORMATION (FOR INDIVIDUALS ONLY)

Date of Birth: (DD/MM/YYYY)

Choose one form of Identification and enter the ID Number.
 Driver's License Voters ID Passport Other

ID No.

ID Country Of Issue

ID Expiry Date (DD/MM/YYYY)

IDENTIFICATION INFORMATION FOR BUSINESS
 Sole Proprietor Partnership Limited Partnership Limited Liability Partnership

 Limited Liability Corporation Corporation Consultant Specified Business

**NEW/CHANGE ADDRESS FORM
GOVERNMENT OF BERMUDA**



Country/State of Incorporation:

Date Incorporated:

Tax ID number:

Company Officers or Partners:

Name: _____

Title _____

Name: _____

Title _____

BANK INFORMATION

Bank Name:

Bank Address:

Sort Code/ ABA /Transit#:

SWIFT Code:

Account Number:

IBAN Number:

Account Type: Savings Checking

Currency:

I authorize Government of Bermuda to verify the information provided on this form (1) to confirm my identity (2) to augment and update currently held information; (3) to provide me with accurate payment; (4) to manage and assess the company's risk; (5) to satisfy information requests; and (6) to meet legal and regulatory requirements.

Authorized Person (Print)

Authorized Signature

Title

Date (DD/MM/YYYY)

**NEW/CHANGE ADDRESS FORM
GOVERNMENT OF BERMUDA**



FOR GOVERNMENT DEPARTMENT OFFICAL USE ONLY

Vendor # _____

Business Unit _____

Authorized By: _____

Print Name: _____

Entered By: _____

Print Name: _____

Date Received

Date Authorized

Date Entered

(DD/MM/YYYY)

(DD/MM/YYYY)

(DD/MM/YYYY)

CHECK of GOVERNMENT INDEBTEDNESS:

Tax Commissioner **Social Insurance Accountant** **General/Debt Collection**

In accordance with section 8.2 of Finance Instructions: If debt exists, arrangement for repayment must be agreed upon before submission of New/Change Address Book Form



GOVERNMENT EMPLOYEE HEALTH INSURANCE ENROLMENT FORM

Department / Pensioner / Quango Name: _____

Name: _____ First _____ Middle _____ Last _____

Appointed: _____/_____/_____. Sex: female male. Date of Birth: _____/_____/_____. Day _____ Month _____ Year _____

I wish to be insured for:

- Full Benefits with public ward
 - Full Benefits with semi-private ward (S.I.S.)
 - Fringe
- Marital Status:
- Single
 - Married
 - Divorced
 - Widower

DEPENDANT COVERAGE *(***Please state under the school name if it is an overseas school***)*
I wish the following dependants to be enrolled for the benefits shown below:

Last Name	First & Middle Name	Sex	Employer or Unemployed		Relationship	D.O.B. (D/M/Y)	Full Public	Full SIS	Fringe
			School / College / Univ.						

Please read these notes carefully:

- Unemployed spouses must by law be enrolled.
- If an employed spouse is insured by their employer for standard hospital benefits only they may be insured with G.E.H.I. for fringe (non-hospital) benefits.
- A new-born baby must be added within 1 month of its date of birth. After that time, there will be a six-month waiting period before the newborn can join G.E.H.I.
- Children in full-time education can continue with G.E.H.I. coverage up to age 26. Minor Child(ren) (MC) coverage is for children in a recognized educational facility or school locally from birth to age 21. Adult Child(ren) (AC) coverage is for children overseas in school up to age 26 and in local school from age 21 to 26. At the age of 26 coverage ceases.
- Semi-private (S.I.S) coverage is not necessary for children. The Bermuda Government provides youth subsidy which covers the local cost of hospital care (at the public ward level) for children under the Bermuda school leaving age and up until age 21 if the child(ren) is enrolled in full-time school in Bermuda.

DECLARATION

I UNDERSTAND THAT PREMIUMS FOR MEDICAL BENEFITS REQUESTED WILL BE DEDUCTED FROM MY WAGES/SALARY IN ADVANCE.

I UNDERTAKE TO REPORT IMMEDIATELY ANY CHANGES TO MY SPOUSE EMPLOYMENT STATUS AND MY CHILD(REN)'S SCHOOL STATUS AND WHEN MY CHILD(REN) TURN(S) AGES 21 AND 26.

I UNDERTAKE TO GIVE NOT LESS THAN ONE MONTH'S NOTICE OF ANY CHANGE I MAY WISH TO MAKE IN THE LIST OF DEPENDANTS VOLUNTARILY ENROLLED BY ME.

I hereby authorise the Accountant General to deduct for those enrolled per above.

Employee Signature: _____ Date: _____/_____/_____. Day _____ Month _____ Year _____

FOR ACCOUNTANT GENERAL'S USE ONLY

G.E.H.I. #: _____ Keyed By: _____ Date: _____/_____/_____. Day _____ Month _____ Year _____

Checked By: _____ Date: _____/_____/_____. Day _____ Month _____ Year _____



ENROLMENT FORM FOR GEHI DENTAL PLAN

This section to be completed by employee

Full Name _____

Address _____

Department _____ Sex Male Female

Date of Birth dd/mm/yr / / /

List below names of Dependents to be covered. Spouses, unmarried children under 16 yrs plus students ages 16-21 are eligible to be enrolled if they are covered under the GEHI Health Plan.

Name	Relationship	Date of Birth

DENTAL COVERAGE SECTION

Please tick the applicable level of dental insurance coverage you wish implemented.

Basic Dental

Comprehensive Dental

I hereby authorize the necessary payroll deduction to be made from my salary.

Signature of Employee _____ Date _____

This section to be completed by Employer (Please print)

Date employee enrolled in Dental Plan dd/mm/yr / / /

Employee Social Insurance Number _____

Department _____

Signed on behalf of Employer _____ Date / / /