GOVERNMENT OF BERMUDA
Ministry of Finance

DEPARTMENT OF SOCIAL INSURANCE

CONTRIBUTIONS/PENSION RE-ASSESSMENT FORM

Full Name: _____

Social Insurance Number: _____

D.O.B: _____

Telephone Number: _____

Email Address: _____

I _____have fully retired as of _____
And would like to have my pension re-assessed.

Print Name: _____

Signature: _____

Date: _____

Address: Government Administration Building, 30 Parliament Street, Hamilton HM12, BERMUDA or
P.O. Box HM 1537, Hamilton HM FX, BERMUDA
Phone: (441) 294-9242 Fax: (441) 292-5267 Email: socialinsuranceinsurance@gov.bm
Website: www.socialinsurance.gov.bm