Bahama Health
FEEL GOOD ABOUT YOUR HEALTHPLAN

Completed form should be sent along with a valid identification to: BHClientRelations@familyguardian.com

BAHAMAHEALTH CLIENT UPDATE FORM

CLIENT UPDATE DETAILS

Effective Date:		
Policy No(s):	Name of Insured:	
Last Name:	First Name:	Initial:
Date of Birth:	NIB Number:	
Street Address:		
P. O. Box:	City:	Island:

ADDRESS/BILLING UPDATE

☐ *Expire previous address effective* _____		☐ *Add new address*
Street Address		
Description		
P. O. Box:	City:	Island:
Email:		

TELEPHONE UPDATE

Home:	Work:
Cell 1:	Cell 2:

ADD PAYEE

Last Name:	First Name:	Initial:
Street Address:		
P. O. Box:	City:	Island:
Home:	Work:	
Cell 1:	Cell 2:	

Do you have other policies with Family Guardian?	☐ *Yes*	☐ *No*
If so, do you wish this Client Update to be forwarded to Family Guardian?	☐ *Yes*	☐ *No*

Dated at _____ this _____ day of _____ 20 ____

_____ Witness

_____ Signature of Insured/Owner

FOR OFFICE USE ONLY

Submitted By: Sales Representative		Date: (mm/dd/yyyy)	
Approved By: Manager/Supervisor		Date: (mm/dd/yyyy)	
Processed By: Client Service Associate		Date: (mm/dd/yyyy)	
Confirmed By: Client Service Supervisor/Manager		Date: (mm/dd/yyyy)	