



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

<input type="checkbox"/> <i>Expire previous address effective</i> _____		<input type="checkbox"/> <i>Add new address</i>
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If so, do you wish this Client Update to be forwarded to Family Guardian?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_

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Witness
Signature of Insured/Owner

### FOR OFFICE USE ONLY

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