



GOVERNMENT OF BERMUDA
Ministry of Finance

Department of Social Insurance
APPLICATION FOR THE SUSPENSION OF SOCIAL INSURANCE CONTRIBUTIONS
IN ACCORDANCE WITH
THE CONTRIBUTORY PENSIONS TEMPORARY AMENDMENT ACT 2020

A. EMPLOYEE DETAILS

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss. <input type="checkbox"/> Dr. <input type="checkbox"/> Other		
Last Name:	First Name:	Middle Name:
Birth Date:	Social Insurance Number:	
Email Address:		
Address: – House Number:	Street Name:	
Parish:	Postal Code:	

B. EMPLOYEE ACKNOWLEDGEMENT and CONSENT

By signing and dating this application I acknowledge and consent to the suspension of Social Insurance contributions between the period July 1st 2020 to June 30th 2021 by me and my employer.

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Signature **Print Name** **Date**

C. EMPLOYER DETAILS

Employer Name:	Are you self-employed? (circle) Yes No
Employer Social Insurance Account Number:	
Email Address:	
Address: – Building Number	Street Name:
Parish:	Postal Code:

D. EMPLOYER ACKNOWLEDGEMENT and CONSENT

By signing and dating this application I/We acknowledge and consent to the suspension of Social Insurance contributions between the period July 1st 2020 to June 30th 2021 by me/us and my employee.

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Signature **Print Name** **Date**

Forms can be submitted to the Department via email at SIsuspend@gov.bm or delivered to our front desk reception.

Please call our hotline 444-2470 for any suspension related queries.

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