New Enrollee/Termination Request Form
Migrant Workers Insurance Program (MWIP)

		EMAIL or FAX to
Name of Employer:		**Delta Pacific Benefit Brokers Ltd**
Address of Employer:		**email:** deltap@delsure.com
Phone Number:		**Fax:** 604 590 0617
Cell Phone:		**Telephone:** 604 590 0680
FAX:		Attn: Andy or Kim
EMAIL:		***Please phone to confirm receipt***
Contact Person:		

Date: ____________

	Name of Employee	Country of Residence	Sex M or F	Date of Birth D/M/Y	Arrival Date D/M/Y	Contract Ends D/M/Y	Date of Termination D/M/Y
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