



Enrollment/Change Form

Please print and complete **all** sections.
See instructions below.

Underwritten by Fidelity Security Life Insurance Company of
Kansas City, Missouri

EMPLOYER INFORMATION:

Group Number 9729526	Employer Name	Plan Selection <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3	Hire Date	Effective Date
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EMPLOYEE INFORMATION

<input type="checkbox"/> ADD <input type="checkbox"/> TERM <input type="checkbox"/> CHG	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Member ID (SSN)	Last Name	First Name	MI	Date of Birth
Home Street Address			City/State/ZIP+4		Home Phone ()	

FAMILY INFORMATION (Only those eligible may be enrolled. Child up to age 26.)

A: Add (enroll) T: Terminate C: Change (change of name)

<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (spouse)	First Name	MI	Date of Birth	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	MI	Date of Birth	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	MI	Date of Birth	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	MI	Date of Birth	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	MI	Date of Birth	Social Security Number

I agree to continue enrollment until canceled due to IRS-qualifying event or canceled by me during annual open enrollment. I further authorize applicable payroll deduction, where available, for premiums due.

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____

Vision insurance is provided on a group plan. If you select this coverage, it must remain in force the entire year unless you have an eligible life event as defined by the IRS.



A not-for-profit ministry of Church of the Brethren Benefit Trust Inc.

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