CHURCH OF THE BRETHREN
INSURANCE SERVICES
A not-for-profit ministry of Church of the Brethren Benefit Trust Inc.
1505 Dundee Avenue • Elgin, Illinois 60120-1619
800-746-1505 • 847-695-0200 • Fax 847-742-6336
insurance@cobbt.org • www.bbtinsurance.org

Insurance Enrollment Information

(Employer Groups)

TO BE COMPLETED BY EMPLOYER

Employer Name _____

Employer Address _____

City _____ **State** _____ **ZIP** _____ – _____

Contact Person _____ **Phone** _____
Premium notice will be sent to this person.

Email _____
We will use your email address solely to communicate with you about Brethren Insurance Services.

❑ Check here if you wish to receive your invoice via email.

TO BE COMPLETED BY EMPLOYEE

Employee Last Name _____ **First Name** _____ **MI** _____

Employee Address _____

City _____ **State** _____ **ZIP** _____ – _____ **Phone** _____

Birth Date _____ **Social Security Number** _____ **Gender** ❑ Male ❑ Female

Hours Worked/Week _____ **Email** _____
We will use your email address solely to communicate with you about Brethren Insurance Services.

Employee's Title _____ **Date of Hire** _____ **Annual Earnings $**_____ **Effective Date of Coverage** _____

Marital Status ❑ Single ❑ Married **Employment Status** ❑ Ordained ❑ Licensed ❑ Lay Employee

Enrollment

Check the boxes of the plan(s) you wish to enroll in.

(Complete Beneficiary Form) ❑ Basic Life and AD&D Amount of coverage $_____ ❑ Supplemental Life ❑ Employee ❑ Spouse ❑ Child (Employee must enroll in Basic Life and fill out the Supplemental Life Enrollment form.)	❑ Dental (Fill out Dental Enrollment form.)	❑ Vision (Fill out Vision Enrollment form.)	**Disability:** ❑ Long-Term ❑ Short-Term (Fill out LTD and/or STD Budget Worksheet now and annually.) ❑ Accident (Fill out Accident form)

SIGNATURES

I understand that misstatements, misrepresentations, or omissions may result in my insurance coverage being void as of its effective date with no benefits payable. I hereby request the group insurance coverage for which I am or may become eligible and authorize deductions from my earnings to serve as payment for any required contributions. My signature below affirms that all information and statements provided on this form are full, complete, and true to the best of my knowledge.

***Fraud Warning Notice:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits a request for enrollment or files a claim containing a false or deceptive statement, is guilty of insurance fraud.*

_____ _____
Signature of Employee *Date* *Signature of Employer* *Date*