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

(Ministers' Group)

Completed forms must be returned to Brethren Insurance Services **WITHIN 31 DAYS OF YOUR HIRE DATE**. If you miss the initial 31-day enrollment period, you may be eligible for late enrollment for life and/or disability coverage. Also, keep in mind that we offer an annual open enrollment for our dental, vision, life and AD&D, long- and short-term disability, and accident plans.

TO BE COMPLETED BY EMPLOYER

Employer or Congregation Name ______________________

Employer Address ______________________

City ______________ **State** _____ **ZIP** _________ –________

Contact Person ______________________ **Phone** ______________

Church Code ______ – __________

OR District ______________

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** _________
Salary + housing allowance. *The day you become eligible.*

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

Enrollment (Eligibility requirement: Must be actively employed and working 20 hours or more per week.)

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

(Complete Beneficiary Form) ❑ Basic Life and AD&D ❑ $50,000 Coverage ❑ ($26,000 for age 65+) ❑ 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*
(church board chair, district executive, treasurer, or other authorized employer representative)