

Enrollment and Change Form

- An employer/church must be located in a District that has agreed to have at least 50% of their eligible Official Workers participating.
- Each participating church must enroll 100% of their Official Workers on staff unless employee is covered under spouse's Employer Plan or Government Plan.
- The employee enrolling in the plan must be actively working and paid for working 20 hours or more per week.
- With the exception of address updates, all changes must be made within 30 days from qualifying date to enroll or they are subject to a six-month waiting period.
- New enrollment effective date is the first day of the month following hire date. If hire date is the first of the month, that will be effective date.

A. GENERAL INFORMATION (ALL SPACES MUST BE COMPLETED)

Employer name: _____ Church code: _____

Employee name: Last: _____ First: _____ MI: _____

Birth date: ____/____/____ Social Security number: _____

Home address: _____

City: _____ State: _____ ZIP Code: _____

Daytime telephone: (____) _____ E-mail: _____

Sex: Male Female Marital status: Married Single Are you a US Citizen/Citizen Resident? Yes No

Date of full-time employment: ____/____/____ Coverage effective date: ____/____/____ Monthly salary: _____

Type: New hire Open enrollment Transfer New church/group Add Dependent Delete Dependent Address change
 Qualifying event (MUST specify) _____ Qualifying event date: ____/____/____

B. BENEFIT ELECTION

Medical benefits: For you only For you and your spouse For you and 1 qualifying dependent* For you and family*

*Qualifying dependents are your spouse and children under age 26 who are not eligible for any other employer plan.

Coverage: A Premium A Standard B Premium B Standard HDHP Premium HDHP Standard

Once enrolled, will you be keeping other health insurance coverage? If yes, please list coverage _____

Life insurance

- Basic Life Insurance for \$30,000 and \$30,000 AD&D coverage is included in the Health Plan for each employee.
- Additional life coverage may be purchased for the employee, spouse, and/or dependents (up to age 23) that are enrolled in the health plan.
- There is a reduction in an employee's coverage beginning at age 65 for Basic Life and 70 for Voluntary Life.

Employee voluntary life: Yes No
If yes, volume amount \$ _____

Volume must be in \$10,000 increments with a minimum of \$10,000 and maximum of \$250,000.

Spouse voluntary life: Yes No
If yes, volume amount \$ _____

If you enroll in Voluntary Life you may purchase voluntary coverage for your spouse. Volume cannot exceed one-half of your volume and must be in \$5,000 increments with a minimum of \$5,000 and maximum of \$50,000.

Child voluntary life: Yes No
If yes, volume amount \$ _____

If you enroll in Voluntary Life you may purchase voluntary coverage for your child(ren). Volume cannot exceed one-half of your volume and must be in \$1,000 increments with a minimum of \$2,000 and maximum of \$10,000. Premium rate is based on one amount for family regardless of the number of children.

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C. PARTICIPANT & DEPENDENT* INFORMATION (ONLY LIST FAMILY MEMBERS TO BE COVERED)

Last name	First name	M.I.	Social Security Number	Relationship	Birth date	Sex M/F
			Same as page 1	Self	Same as page 1	Pg 1

*Eligible dependents are your spouse and children under age 26 who are not eligible for any other employer plan.

D. BENEFICIARY DESIGNATION

This beneficiary designation is applicable to your Life and AD&D benefits.

Life insurance and AD&D	Percentage**	Relationship	Birth date	Social Security number
Primary beneficiary* _____	_____	_____	/ /	_____
Primary beneficiary* _____	_____	_____	/ /	_____
Primary beneficiary* _____	_____	_____	/ /	_____
Secondary beneficiary* _____	_____	_____	/ /	_____
Secondary beneficiary* _____	_____	_____	/ /	_____
Secondary beneficiary* _____	_____	_____	/ /	_____

*show full given name **total percentage of primary must equal 100% and total percentage of secondary must equal 100%

E. REQUIRED SIGNATURES

I authorize my employer to arrange for me to be covered under the terms of the plans I have chosen.

Employee signature: _____ Date: ____/____/____

Authorized employer representative: _____ Date: ____/____/____



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