Bethany Benefit Service

P.O. Box 316560, Chicago, Illinois 60631
Fax: (773) 784-2249 | Email: bethany@covchurch.org

Health Insurance Addition

Instructions: Fill out and return this form to Bethany Benefit Service.

I previously elected to waive health insurance coverage through Bethany Benefit Service. This letter is to request the addition of health insurance to my current policy. I and my employer understand and agree to the increase in premium rate due to this change.

1. YOUR INFORMATION

Name: _____ SSN: _____

Effective Date of Change: _____ /_____ /_____

Check one: ☐ Individual Coverage ☐ Family Coverage
☐ Individual dental/vision only ☐ Family dental/vision only

2. DEPENDENT INFORMATION (If electing family coverage)

Please note: children through age 25 are eligible.

Spouse name: _____ ☐ Male ☐ Female

Date of birth: _____ /_____ /_____ SSN: _____

Child name: _____ ☐ Male ☐ Female

Date of birth: _____ /_____ /_____ SSN: _____

Child name: _____ ☐ Male ☐ Female

Date of birth: _____ /_____ /_____ SSN: _____

Child name: _____ ☐ Male ☐ Female

Date of birth: _____ /_____ /_____ SSN: _____

Child name: _____ ☐ Male ☐ Female

Date of birth: _____ /_____ /_____ SSN: _____

3. AUTHORIZED SIGNATURES

This form, signed by the policyholder and an authorized representative of the employer (treasurer, business manger, etc.), is to request the addition of benefits for the indicated policyholder as stated above.

Policyholder Signature: _____ Date: _____ /_____ /_____

Treasurer/Businesss
Manager Signature: _____ Date: _____ /_____ /_____