Bethany Benefit Service

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

Dependent Addition

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

This letter is to request the addition of my dependent(s) to my current coverage with Bethany Benefit Service.
I and my employer agree to the change in premium rate if I do not already have family health insurance coverage.

1. YOUR INFORMATION

Name: _____ SSN: _____

Effective Date of Change: _____ / _____ / _____

Check one: ☐ Full health coverage
☐ Dental/vision only

2. DEPENDENT INFORMATION

Please note: children through age 25 are eligible. Legal documentation must be included for adoptions.

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 dependents for the indicated policyholder as stated above.

Signature: _____ Date: _____ / _____ / _____

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