5. DEPENDENT INFORMATION

Include family members' information. Children under age 26 are eligible. Verification of marriage, birth or adoption may be requested.

Name of spouse: ______________________ Name of child: ______________________

SSN: ______________________ SSN: ______________________

Date of Birth: ______ /______ /______ Male Female Date of Birth: ______ /______ /______ Male Female

Name of child: ______________________ Name of child: ______________________

SSN: ______________________ SSN: ______________________

Date of Birth: ______ /______ /______ Male Female Date of Birth: ______ /______ /______ Male Female

Name of child: ______________________ Name of child: ______________________

SSN: ______________________ SSN: ______________________

Date of Birth: ______ /______ /______ Male Female Date of Birth: ______ /______ /______ Male Female

6. LIFE INSURANCE BENEFICIARIES

(only complete if full-time employee)

Primary Beneficiary

Name: ______________________ Relationship: ______________________

LAST NAME FIRST NAME MIDDLE INITIAL

Address: ______________________ SSN: ______________________

Contingent Beneficiary

Name: ______________________ Relationship: ______________________

LAST NAME FIRST NAME MIDDLE INITIAL

Address: ______________________ SSN: ______________________

7. STATEMENT OF INTENT

I request coverages offered by the Evangelical Covenant Church *(indicated above)*. I agree to the terms and conditions of participation and understand that coverage will lapse upon failure to pay required premiums. *Both signatures are required in order to enroll.*

Employee Signature: ______________________ Date: ______ /______ /______

Employer Signature: ______________________ Date: ______ /______ /______

8. WAIVER OF HEALTH INSURANCE COVERAGE

I hereby waive health insurance coverage because I receive health insurance through through another employer (my spouse's or a second job of my own) or a government-sponsored plan.

Signature: ______________________ Date: ________ /________ /________

9. TERMINATION OF EMPLOYMENT

If you are moving from one Covenant employer to another, you must notify both your current conference office and Covenant Benefits. Before terminating your employment with the Covenant Church, it is vital that you notify Covenant Benefits as soon as possible to avoid interruption of coverage. If you are leaving Covenant employment, you will be offered COBRA-like benefits.

Continuation of Coverage

Covenants Benefits allows you to continue your current health insurance for up to 18 months after termination of employment or termination of insurance due to ineligibility, and longer in some circumstances. Coverage ceases when you begin new insurance or fail to make payments.

Covenant employers are not obligated to offer COBRA benefits since they are exempt from this law, but Covenant Benefits does so as a service. Election and payment of the continued coverage is the responsibility of the terminated employee and not of the previous employer, unless otherwise negotiated by the parties.

You have 60 days from your last date of employment to elect Continuation of Coverage in writing. Coverage is reinstated with no lapse from previous termination date only after Covenant Benefits receives request in writing and first payment. Premiums will be at a cost slightly higher than regular premiums and can be paid in monthly installments directly to Covenant Benefits.

Continuation of Coverage for Dependents

Dependents who become ineligible for coverage under the policy can apply for Continuation of Coverage. Generally, these include:

1. A spouse separated by a divorce.
2. Any child upon reaching his or her 26th birthday. Some eligibility exceptions apply to disabled children who are 26 or older.

If you have any questions about Continuation of Coverage, contact Covenant Benefits.

Statement of Acknowledgment

I have read and understand the above information regarding Continuation of Coverage.

Employee Signature *(required if enrolling in single or family health insurance):*

_______________________________________ Date: _____ /_____ /_____

Spouse's Signature *(required if enrolling in family health insurance):*

_______________________________________ Date: _____ /_____ /_____