COVENANT BENEFITS

8303 W. Higgins Road, Chicago, IL 60631 | FAX: 800-313-8955 | EMAIL: benefits@covchurch.org

Minister and Ministry Staff Enrollment Form for Health, Life, and Long-Term Disability Insurance

Instructions: This enrollment form is for ministers and employees of the Evangelical Covenant Church, its local churches and its affiliated ministries (i.e. camps, radio station, regional conference offices, etc.). Employees of Covenant Ministries of Benevolence and Covenant schools should consult their employer regarding internal benefits. *Print or type your answers.*

1. **Your Information.** Please use your full legal name and mailing address. All personal insurance information, such as ID cards, will be mailed directly to the address provided.
2. **Type of Coverage.** Select the Single or Family health coverage plan that best fits your needs. Please note that you may not waive health insurance coverage unless you receive health insurance from another employer plan. If you waive health insurance, you will still be enrolled in life and long-term disability benefits if working full-time.
3. **Employer Information.** Provide the full name and address of your employer, including the nine-digit zip code, if possible, and phone number. Your insurance premiums will be billed to this address. Please note that your Date of Hire refers to the date you started working for your employer. Billing is always for an entire month of coverage, never pro-rated. Coverage begins on date of hire or date enrollment is accepted.
4. **Employment Information.** Occupation and salary computation is used to calculate Long-Term Disability premiums and benefits. When computing salary data, do not include reimbursement for mileage or other business expenses. If you are provided a parsonage as a benefit of employment, check yes for “parsonage provided.” This will count as an additional 33% to your base salary. If you are given a housing allowance, indicate the amount in the space provided. These numbers should agree with amounts you report to the IRS and/or to the Covenant Pension Plan.
5. **Dependent Information.** Children through age 25 are eligible for benefits.
6. **Life Insurance Beneficiaries.** If you are a full-time employee, designate a primary and contingent beneficiary. You may change your designation at any time by notifying Covenant Benefits in writing. Please note that only full-time employees areeligible for life and long-term disability insurance. Full-time employees may not opt out of these benefits.
7. **Statement of Intent.** Sign, date, and return thisform to Covenant Benefits. You should keep acopy for your records. You may wish to email or faxthis form to ensure timely processing.
8. **Waiver of Health Insurance Coverage.** Sign if youwish to only elect life and long-term disability insurances. You may only waive health insurance if you receive it from your spouse’s employer, asecond job of your own, or the government Marketplace.
9. **Termination of Employment.** With your signature onthe back of this form you acknowledge that you areeligible to continue health coverage after ending employment. If you elect to waive health insurance, then you are not eligible for Continuation of Coverage and do not need to sign this section.

Carriers: Highmark Blue Cross Blue Shield (medical), Delta Dental Plan of Illinois (dental), EyeMed (vision), Express Scripts (prescription), Unum (life, accidental death and dismemberment, and long-term disability), 98point6

COVENANT BENEFITS
Post Office Box 316560, Chicago, Illinois 60631 | FAX: (773) 784-2249 | EMAIL: benefits@covchurch.org

Minister and Ministry Staff Enrollment Form for Health, Life, and Long-Term Disability Insurance

Instructions: Fill out and submit this form by mail, email, or fax to Covenant Benefits. *Please print legibly.*

1. YOUR INFORMATION

Name: _____
LAST NAME LAST NAME MIDDLE INITIAL

SSN: _____ Date of Birth: _____ /_____ /_____ Male | Female

Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____ Phone #: _____

2. TYPE OF COVERAGE

Select the coverage that best fits your needs.

Medical/Prescription *(choose one)*

- ☐ None ☐ Single
- ☐ Employee plus child(ren)
- ☐ Employee plus spouse
- ☐ Full family (child(ren) and spouse)

Dental/Vision *(choose one)*

- ☐ None ☐ Single
- ☐ Employee plus child(ren)
- ☐ Employee plus spouse
- ☐ Full family (child(ren) and spouse)

3. EMPLOYER INFORMATION

Name: _____ Date of Hire: _____ /_____ /_____

Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____ Phone #: _____

Regional conference in which employer is located: _____

4. EMPLOYMENT INFORMATION

Effective Date of Insurance: _____ /_____ /_____ *(see eligibility policy if different from date of hire)*

Occupation: ☐ ECC-licensed minister ☐ Other staff *(including ministers not holding ECC license)*

Hours: ☐ Full-time *(30+ hours per week)* ☐ Part-time *(20-29 hours per week)*

Annual Base Salary: $ _____ *(Include SECA and FICA, if paid directly to employee)*

Housing Allowance: $ _____ *(Do not include in base salary, licensed ministers only)*

Parsonage provided? ☐ Yes ☐ No *(Do not include in base salary, licensed ministers only)*

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 asecond 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: _____ /_____ /_____