COVENANT BENEFITS

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

Covenant Offices Enrollment Form for Health, Life, Long-Term Disability Insurance, and Flexible Spending

Instructions: This enrollment form is for Covenant Offices, National Covenant Properties, and Paul Carlson Partnership employees.
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 employee only, employee plus child(ren), employee plus spouse or full family health coverage 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. **Dependent Information.** Children through age 25 are eligible for benefits.
4. **Life Insurance Beneficiaries.** Designate a primary and contingent beneficiary. You may change your designation at any time by providing written notification to Covenant Benefits.
5. **Statement of Intent.** Sign and date this enrollment form then submit to Covenant Benefits.
6. **Continuation of Coverage.** Your signature acknowledges that you are eligible 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.
7. **Flexible Spending Account.** Complete this section whether you would like funds withheld from your payroll or not. You may request a complete list of eligible expenses from Covenant Benefits.

1. YOUR INFORMATION

Name: _____
LAST NAME LAST NAME MIDDLE NAME

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. 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

4. LIFE INSURANCE BENEFICIARIES

Primary Beneficiary

Name: _____ Relationship: _____
LAST NAME FIRST NAME MIDDLE INITIAL

Address: _____ SSN: _____

Contingent Beneficiary

Name: _____ Relationship: _____
LAST NAME FIRST NAME MIDDLE INITIAL

Address: _____ SSN: _____

5. STATEMENT OF INTENT

I request coverages offered by the Evangelical Covenant Church indicated above and agree to payroll deductions, if applicable.

Employee Signature: _____ Date: _____ /_____ /_____

6. CONTINUATION OF COVERAGE ACKNOWLEDGEMENT

Covenant Benefits allows you to continue your current health insurance coverage 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.

The Covenant is not obligated to offer COBRA benefits by law, but does so as a service. Payment of the continued coverage is the responsibility of the terminated employee and not of the Covenant.

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.

Dependents who become ineligible for coverage under the policy can also apply for Continuation of Coverage. Generally, these include a spouse separated by a divorce, or any child upon reaching his or her 26th birthday. (Some eligibility exceptions apply to disabled children age 26 and older.)

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: _____ /_____ /_____

8. FLEXIBLE SPENDING ACCOUNT(S) Full Name: _____ Current Year: _____

☐ I hereby elect to participate in the Flexible Spending Account(s)
☐ I hereby elect NOT to participate in the Flexible Spending Account(s)

Annual Election

Health Care FSA (for your and your family's health care expenses)
(Please check IRS regulation for yearly maximum limits) $ _____
(Period for incurring expenses: date of eligibility to March 15 of the following year)

Dependent Care FSA (for eligible childcare, dependent care or elder care expenses)
(Please check IRS regulation for yearly maximum limits) $ _____
(Period for incurring expenses: date of eligibility to December 31 of the current year)

DEPENDENT/SPOUSE INFORMATION: (please list if not already on file)

Children up to age 26 are eligible.

First Name	Last Name	Gender	Relationship	Date of Birth MO/DAY/YR
		M ☐ F ☐		
		M ☐ F ☐		
		M ☐ F ☐		
		M ☐ F ☐		
		M ☐ F ☐		

ACCOUNT ELECTION AUTHORIZATION:

I hereby authorize Evangelical Covenant Church to withhold from my salary the above amounts per pay period on a pre-tax basis. I understand that contributions to my Flexible Spending Account can only be reimbursed for eligible expenses within the account, and that any amounts remaining in my account not used for eligible expenses during the plan year will be forfeited in accordance with current plan provisions and tax laws. I understand I have until June 15 for health care expenses and March 15 for dependent care expenses of each year to submit expenses incurred during the prior Plan Year. I further understand that the flexible compensation reductions will be in effect for the Plan Year and cannot be revoked unless I experience a change in family status as recognized under the plans.

Unpaid expenses from my Covenant Benefits administered plan(s), such as deductibles and co-pays, will be automatically considered through my Health Care Spending Account. Health care expenses not processed through Covenant Benefits medical, prescription or dental plans will need to be manually submitted to receive reimbursement. See Covenant Benefits for a list of eligible expenses.

I will not claim these charges as a deduction on my personal income tax return.
I will not be reimbursed by any other source for these charges.

Signature (required) _____ Date: _____ /_____ /_____