COVENANT BENEFITS

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

Enrollment Form for Retiree Health and Medicare Supplemental Insurance

Instructions: Fill out and submit this form by mail, email, or fax to Covenant Benefits *(see above for address).*
Please print legibily.

Name: _____
LAST NAME FIRST NAME MIDDLE INITIAL

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

HOME ADDRESS

Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____ Phone #: _____

BILLING ADDRESS *(if different than home address)*

Address: _____

City: _____ State: _____ Zip Code: _____

E-mail: _____ Phone #: _____

BENEFITS INFORMATION

Date of Retirement: _____ /_____/ _____ Date to begin benefits *(if different than retirement date):* _____ /_____ /_____

Employer from which retiring: _____ City: _____ State: _____

Type of Insurance: ☐ Full coverage (medical, prescription, dental, vision) ☐ Dental and vision only

DEPENDENT INFORMATION

☐ I request coverage for my eligible dependents. ☐ I do not request coverage for my eligible dependents.

Name of spouse: _____ Name of child: _____

SSN: _____ SSN: _____

Date of Birth: _____ /_____ /_____ Date of Birth: _____ /_____ /_____ ☐ Male ☐ Female

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.

Signature: _____ Date: _____

This enrollment form is for qualified retiring employees of Covenant organizations. If you have any questions, please contact Covenant Benefits at (800) 313-8955.

Enrollment Instructions

1. This application must be received within 30 days of retirement. When sending your completed application, please include a copy of your and your spouse's Medicare cards (if applicable).

2. When you or your spouse becomes eligible for Medicare, insurance premiums are reduced and coverage becomes secondary to Medicare. Please send Covenant Benefits a copy of your Medicare card when you become eligible.

3. If you are re-employed full-time by a Covenant organization, you must enroll for benefits under your employer. This Medicare supplement insurance will be discontinued for the duration of your employment.

4. You will receive an invoice for insurance premiums after your application has been processed.

Carriers: Highmark Blue Cross Blue Shield (medical), Delta Dental Plan of Illinois (dental), DeltaVision (vision), Express Scripts (prescription)