



COVENANT BENEFITS

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

Instructions: Fill out and return this form to Covenant Benefits Service.

This letter is to request the addition of my dependent(s) to my current coverage with Covenant Benefits 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 manager, etc.), is to request the addition of dependents for the indicated policyholder as stated above.

Signature: _____ Date: ____ / ____ / ____

Treasurer/Business Manager Signature: _____ Date: ____ / ____ / ____