



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

I previously elected to waive health insurance coverage through Covenant Benefits. This letter is to request the addition of health insurance to my current policy due to the loss of my previous health insurance policy. I and my employer understand and agree to the increase in premium rate due to this change.

1. YOUR INFORMATION

Name: _____ SSN: _____

Effective Date of Change: ____ / ____ / ____

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)

2. DEPENDENT INFORMATION (If electing family coverage)

Please note: children through age 25 are eligible. Legal documentation of marriage, birth or adoption may be requested.

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 manger, etc.*), is to request the addition of benefits for the indicated policyholder as stated above.

Policyholder Signature: _____ Date: ____ / ____ / ____

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