CHURCH OF THE BRETHREN
INSURANCE SERVICES
A not-for-profit ministry of Church of the Brethren Benefit Trust Inc.
1505 Dundee Avenue • Elgin, Illinois 60120-1619
800-746-1505 • 847-695-0200 • Fax 847-742-6336
insurance@cobbt.org • www.bbtinsurance.org

Employee Application

Brethren Medical Plan

1. ENROLLMENT INFORMATION

Enrollment: ❑ New ❑ Continuation ❑ Special (if special, reason _____)

Employer Name _____

Job Title: _____ **Annual Earnings** _____

Effective date: _____ **Hire Date** _____
(The day you become eligible.)

Open Enrollment: ❑ New Member ❑ Plan Change ❑ Add Dependents

Employee Last Name _____ **First Name** _____ **MI** ____

Home Mailing Address _____

City _____ **State** _____ **ZIP** _____ – _____

Date of Birth _____ **Social Security Number** _____ **Phone** _____

We will use your email address solely to communicate with you about Brethren Insurance Services.

Gender ❑ Male ❑ Female **Email** _____

Marital Status: ❑ Single ❑ Married

Employment Status: ❑ Active Employee ❑ Inactive Employee
❑ If Pre-65 Retiree, Retirement Date _____

Continuation — Maximum of 18 months. Available to terminated employees previously enrolled in Brethren Medical Plan.

Continuation Start Date _____ Projected End Date _____

Previously covered with group as:
❑ 1. Employee (Termination of employment, reduction in hours, other)
❑ 2. Spouse (Divorce from employee, death of employee, other)
❑ 3. Dependent (Reached age limit, married, no longer full-time student, other)
❑ 4. Spouse & Dependents (Divorce from employee, death of employee, other)

2. COVERAGE APPLIED FOR

Check one: ❑ Employee ❑ Employee + Spouse ❑ Employee + Child(ren) ❑ Family

Check one: ❑ PPO1500 ❑ HDHP2500 ❑ PPO2500 ❑ HDHP6000

3. FAMILY COVERAGE INFORMATION

Complete for your spouse and all children to be covered.

Last Name (if different) _____ **First Name** _____ **MI** _____

Spouse Date of Birth _____ **Social Security Number** _____

Last Name (if different) _____ **First Name** _____ **MI** _____

❑ Son ❑ Daughter **Date of Birth** _____ **SSN** _____ Full-time student? ❑ **Y** ❑ **N**

Continued...

Employee Name _____ **Employee SSN** _____

"Family Coverage Information" Continued...

Last Name (if different) _____ **First Name** _____ **MI** _____

❑ Son ❑ Daughter **Date of Birth** _____ **SSN** _____ Full-time student? ❑ **Y** ❑ **N**

Last Name (if different) _____ **First Name** _____ **MI** _____

❑ Son ❑ Daughter **Date of Birth** _____ **SSN** _____ Full-time student? ❑ **Y** ❑ **N**

If you and the other parent of the dependents listed above are divorced or separated, who has custody of the dependents? ❑ Employee ❑ Other Parent
Who has financial responsibility for health expenses? ❑ Employee ❑ Other Parent

4. OTHER INSURANCE INFORMATION

Complete ONLY if you or your dependents have other group insurance.

Do you or any of your family members have OTHER GROUP COVERAGE **that will not be cancelled** when this application is approved? ❑ Y ❑ N
If yes, complete the following section. Check all that apply. This information will be used to coordinate benefits with the other insurance company.

Health coverage for: ❑ Self ❑ Spouse ❑ Dependent Child ❑ Other **Policy Number** _____ ❑ Single ❑ Family

Name of Insured _____ **SSN** _____ **Date of Birth** _____

Employer Name _____

Insurance Company Name _____ **Telephone** _____

Address _____

City _____ **State** _____ **ZIP** _____

5. MEDICARE/ESRD COVERAGE INFORMATION

If you or your dependents are covered under your employer's health plan and covered by Medicare, please complete.

Name _____ HIC # _____

Medicare A	**Medicare B**	**ESRD Dialysis**	**Disability**
Start Date _____	Start Date _____	Start Date _____	Start Date _____

Name _____ HIC # _____

Medicare A	**Medicare B**	**ESRD Dialysis**	**Disability**
Start Date _____	Start Date _____	Start Date _____	Start Date _____

6. APPLICATION FOR COVERAGE

To the best of my knowledge and belief, the information provided on this application is true and correct. Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material, thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I understand that this form enrolls those eligible persons listed above in the Medical Plan as described in the agreement between the plan and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered. I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Brethren Medical Plan and Blue Cross Blue Shield may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Brethren Medical Plan's Notice of Privacy Practices is included in the Plan document, or from the Brethren Medical Plan Privacy Office.

_____ _____
Authorized Employer Signature Date

_____ _____
Employee Signature Date