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

Waiver of Coverage

Brethren Medical Plan

Please complete this form if you are waiving coverage. If you are not declining coverage, please do not complete this form.

EMPLOYEE INFORMATION

Employer Name _____

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

Home Mailing Address _____

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

Hire Date_____ **Social Security Number**_____
(The day you become eligible.)

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

If you are declining health coverage for yourself, your spouse, or your children because of other coverage, you may in the future be able to enroll yourself, your spouse, and/or your children in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new spouse or child as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and them, provided you request enrollment within 31 days of the marriage, birth, adoption, or placement for adoption. ***I acknowledge that I, along with my spouse and/or children (if any), were provided an opportunity to enroll in the Brethren Medical Plan.***

❑ **I do not wish to enroll for health coverage.** I hereby elect not to enroll in the Brethren Medical Plan for the reason indicated below and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made available with the company.

Reason:
❑ Covered under spouse's employer-based health insurance plan (Please complete **Other Insurance Information** section below)
❑ Covered under a Medicare supplement plan
❑ Other (please explain) _____

Your signature is required below for any waiver of coverage.

OTHER INSURANCE INFORMATION

Complete ONLY if you have other group insurance.

If you or any of your family members have other group coverage, please complete the following section. Check all that apply.

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** _____

_____ _____
Signature of Employee *Date*