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

Election Form
Wellness Program Participation

For plan year _____

ACCOUNT INFORMATION

Employer Name _____

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

Employee Address _____

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

Birth Date _____ **Social Security Number** _____ **Gender** ❑ Male ❑ Female

E-mail _____

We will use your e-mail address solely to communicate with you about Brethren Insurance Services.

WELLNESS PROGRAM ELECTION

❑ I **elect** to participate in the Wellness Program.

❑ I **decline** to participate in the Wellness Program.
(I understand by declining that my portion of the medical premium may be increased by my employer as a result of this declination.)

SIGNATURE

I understand that misstatements, misrepresentations, or omissions may result in my insurance coverage being void as of its effective date with no benefits payable. I hereby request the group insurance coverage for which I am or may become eligible and agree to pay the premium for this coverage. My signature below affirms that all information and statements provided on this form are full, complete, and true to the best of my knowledge.

***Fraud Warning Notice:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits a request for enrollment, or files a claim containing a false or deceptive statement is guilty of insurance fraud.*

_____ _____
Signature of Employee *Date*

_____ _____
Signature of Employer *Date*

_____
Title of Employer Representative