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 & Salary Reduction Agreement

Brethren FlexCare

(Ministers' Group)

Completed forms must be returned to Brethren Insurance Services **WITHIN 31 DAYS OF YOUR HIRE DATE**. If you miss the initial 31-day enrollment period, you may be eligible for late enrollment for life and/or disability coverage. Also, keep in mind that we offer an annual open enrollment for our dental, vision, life and AD&D, long- and short-term disability, and accident plans.

For plan year ________________

PART I — IDENTIFYING INFORMATION

Employee Last Name ____________________________ **First Name** ______________________ **MI** ____

Employee Address ____

City ______________________________ **State** ______ **ZIP** ________ – ______ **Phone** ________________

Birth Date __________________________ **Social Security Number** ____________________________

Email ____

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

Employer ____

PART II — PREMIUMS

Please refer to the enclosed Brethren FlexCare Election Form Instructions. Remember to include only your portion of the premium. If entering the plan mid-year, please prorate the amount to the number of months remaining in the calendar year.

If you elect or change coverage, be sure to complete and submit enrollment forms to BBT.

Basic Insurance Benefits

A. Long-Term Disability
Enter the **employee's** annualized premium for this plan. A. ____________

B. Basic Life and Accidental Death and Dismemberment
Enter the **employee's** annualized premium for this plan. B. ____________

Note: The employee's portion of the Life insurance premium may be withheld on a pre-tax basis for a benefit of up to $50,000. **Supplemental Life insurance is available, but may not be paid with pre-tax premiums.**

Optional Insurance Benefits

C. Dental Plan ❑ **Option 1** ❑ **Option 2** ❑ **Option 3**
If you wish to elect this coverage, enter the **employee's** annualized cost of this plan. C. ____________
❑ Employee Only ❑ Employee + One ❑ Family ❑ No Coverage Elected

D. Vision Plan ❑ **Option 1** ❑ **Option 2** ❑ **Option 3**
If you wish to elect this coverage, enter the **employee's** annualized premium for this plan. D. ____________
❑ Employee Only ❑ Employee + One ❑ Family ❑ No Coverage Elected

E. Accident ❑ **Option 1** ❑ **Option 2** ❑ **Option 3**

If you wish to elect this coverage, enter the **employee's** annualized premium for this plan. E. ____________

❑ Employee Only ❑ Employee + Spouse ❑ Employee + Child(ren) ❑ Family ❑ No Coverage Elected

Note: The premium amounts above will be withheld by your employer on a pre-tax basis.

F. Short-Term Disability

Enter the **employee's** annualized premium for this plan. F. ____________

PART III — TOTAL

G. Total dollars you have elected to spend (add lines A-F) G. ____________

PART IV — SIGNATURES

I hereby authorize my employer to reduce my compensation by the amount indicated on line G above.

I understand that the elections I have made above are irrevocable for the plan year unless I have a qualified change in status. Changes can be made only within 31 days of the date of a qualified change in status.

____ ____________________

Signature of Employee *Date*

____ ____________________

Signature of Employer *Date*

(church board chair, district executive, treasurer, or other authorized employer representative)

____

Title of Employer

Note: Brethren Benefit Trust assumes no responsibility for submitting any federal or state income tax documents on your behalf. That responsibility rests with you and your employer.

Please keep a copy of this Salary Reduction Agreement for your records.