CHURCH OF THE BRETHREN
INSURANCE SERVICES
A not-for-profit ministry of Church of the Brethren Benefit Trust Inc.
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Election Form Instructions

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.

When completing this form, it is essential that you know what **your share** of the cost of each premium will be. Contact your congregation or employer to confirm the amount of the contribution that will be made on your behalf. Annual Conference guidelines recommend that the employer pay two-thirds and the employee one-third of the Basic Life and Accidental Death and Dismemberment and Long-Term Disability insurance premiums. The congregation or employer may, at its discretion, fund optional programs as well.

WHO CAN PARTICIPATE

To qualify, a person must be —

1. Employed a minimum of 20 hours a week for a Church of the Brethren congregation, district, camp, or other eligible agency;
2. Classified as a pastor who has terminated employment with one church and has contracted with another but has not begun work, but will begin work within one year; or
3. Classified as a pastor on the pastoral placement listing for up to one year after terminating employment with the most recent congregation.

BASIC REQUIREMENTS

Any eligible person may participate in any of the plans listed under A through G below. Please refer to the Elgibility Information document for detailed eligibility guidelines. Through Brethren FlexCare you are able to have your employer withhold your share of the premiums on a pre-tax basis.

Note: If you did not enroll in the Life, Long-Term Disability, or Short-Term disability plans within 31 days of your first day of employment, or during open enrollment, and you now wish to elect any of these coverages, then you must go through the late enrollment process. Contact Brethren Insurance Services for further information.

PART I — IDENTIFYING INFORMATION

Print or type your name, home address, home telephone number, birth date, Social Security number, email address, and the name of your employer or congregation.

PART II — PREMIUMS

To complete Part II you will need the current year's insurance rates.

A. Long-Term Disability
From the LTD budget worksheet, enter the **employee's** annualized premium for this plan on line A. If your employer does not follow the two-thirds/one-third Annual Conference guidelines, you will need to enter the employee's annualized amount based on your congregation or employer's funding policy.

B. Basic Life and Accidental Death and Dismemberment
From the rate sheet, enter the **employee's** annualized premium for this plan on line B. If your employer does not follow the two-thirds/one-third Annual Conference guidelines, you will need to enter the employee's annualized amount based on your congregation or employer's funding policy.

Note: The employee's portion of 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.**

C. Dental Plan
If you wish to elect the Dental Plan, check the boxes for the option and coverage level you desire and fill out the Dental Plan Enrollment form. Refer to the rate sheet and enter the annualized amount of the coverage you have elected on line C. **It is assumed that the entire premium amount will be paid by the employee.** If your employer will contribute a portion of the premium, enter only the annualized premium you will owe after your employer's contribution.

D. Vision Plan
If you wish to elect the Vision Plan, check the boxes for the option and coverage level you desire and fill out the Vision Plan Enrollment form. Refer to the rate sheet and enter the annualized amount of the coverage you have elected on line D. **It is assumed that the entire premium amount will be paid by the employee.** If your employer will contribute a portion of the premium, enter only the annualized premium you will owe after your employer's contribution.

E. Accident
If you wish to elect the Accident Plan, check the boxes for the option and coverage level you desire and fill out the Accident Plan Enrollment form. Refer to the rate sheet and enter the annualized amount of the coverage you have elected on line E. **It is assumed that the entire premium amount will be paid by the employee.** If your employer will contribute a portion of the premium, enter only the annualized premium you will owe after your employer's contribution.

F. Short-Term Disability
From the STD budget worksheet, enter the **employee's** annualized premium for the plan on line F. **It is assumed that the entire premium amount will be paid by the employee.** If your employer will contribute a portion of the premium, enter only the annualized amount you will owe after your employer's contribution.

PART III — TOTAL

Add lines A-F and enter the sum on line G. This is the total amount you have elected to spend in the upcoming plan year.

PART IV — SIGNATURES

Your signature certifies that these are the choices you have made under Brethren FlexCare, and that you understand they are irrevocable for the plan year unless you have a qualified change in status. Your signature also authorizes your employer to implement the salary reduction shown on line H.

Your employer must sign the election form attesting to any premium subsidies indicated. Your employer's signature also acknowledges the salary reduction indicated on line H.