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
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insurance@cobbt.org • www.bbtinsurance.org

Medicare Supplement Plan Enrollment

Brethren Medical Plan

This is an enrollment form for Medicare supplement coverage provided by Brethren Medical Plan.
If your employer has 20 or more employees, the medical plan provided by your employer will be primary and Medicare will be secondary. If your employer has fewer than 20 employees, Medicare will be primary and the Brethren Medical Plan Medicare Supplement Plan will be secondary.

EMPLOYEE INFORMATION

Active, inactive, or retired employee (complete if enrolling for coverage)

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

Employee/Retiree Address _____ **City** _____ **State** ____ **ZIP** _____

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

Birth Date _____ **Social Security Number** _____ **Marital Status** ❑ Single ❑ Married

If married, is your spouse now enrolled in the Brethren Medical Plan Medicare Supplement Plan? ❑ Yes ❑ No

EMPLOYEE COVERAGE APPLIED FOR

Check one: ❑ ***Option 1*** ❑ ***Option 2***

Employment Status

❑ ***Active employee eligible for Medicare***
Are you on Medicare disability? ❑ Yes _____ ❑ No
date of disability
Employer _____
Does your employer have 20 or more employees? ❑ Yes ❑ No
Date of Hire _____ Hours worked per week _____

❑ ***Inactive employee under age 65***
Are you on Medicare disability? ❑ Yes _____ ❑ No
date of disability
Previous Employer _____

❑ ***Retired employee***
Are you on Medicare disability? ❑ Yes _____ ❑ No
date of disability
Date of retirement _____
Previous Employer _____

What is the Medicare Claim Number shown on your Medicare card? ____/_____/____ **Are you covered under Medicare, Parts A (hospitalization) and B (medical)?** ❑ Yes ❑ No **What is the effective date shown on your Medicare card?** _____

SPOUSE INFORMATION

Spouse of active, inactive, or retired employee (complete if enrolling for coverage)

Employee/Retiree Name _____ **Employee/Retiree Social Security Number** _____

Spouse's Last Name _____ **First Name** _____ **MI** ____

Spouse's Birth Date _____ **Spouse's Social Security Number** _____

SPOUSE COVERAGE APPLIED FOR

Check one: ❑ ***Option 1*** ❑ ***Option 2***

Status

❑ Spouse of active employee
❑ Spouse of inactive employee under age 65
❑ Spouse of retired employee

Are you on Medicare disability? ❑ Yes _____ ❑ No
date of disability

What is the Medicare Claim Number shown on your Medicare card? ____/_____/____

Are you covered under Medicare, Parts A (hospitalization) and B (medical)? ❑ Yes ❑ No

What is the effective date shown on your Medicare card? _____

OTHER COVERAGE

To the best of your knowledge —	**Retiree/Employee**		**Spouse**	
	Yes	**No**	**Yes**	**No**
1. Are you currently enrolled in the Brethren Medical Plan?	❑	❑	❑	❑
2. Do you currently have another Medicare supplement policy in force?	❑	❑	❑	❑
3. Do you intend to replace your current Medicare supplement policy with the Brethren Medical Plan Medicare Supplement Plan?	❑	❑	❑	❑
4. Do you have any other health insurance coverage that provides benefits similar to the Brethren Medical Plan Medicare Supplement Plan?	❑	❑	❑	❑

If you answered "yes" to question 2 or 4, please give the following information —

Other insurance information	**Date coverage began**	**Date coverage ended**	**Type of policy**
Insurance Company Name:			
Insurance Company Address:			
Insurance Company Telephone Number:			
Insurance Company Name:			
Insurance Company Address:			
Insurance Company Telephone Number:			

SIGNATURES

Please read and sign below if enrolling for coverage.

I understand that to enroll in this plan, I:

1. Must be covered under Medicare, Part A (hospitalization) and Part B (medical).
2. Must be a Medicare-eligible employee or retiree of a Church of the Brethren-affiliated employer.

I authorize all health care providers to release any necessary medical information to BBT to process claims. I understand that this information will be shared with third parties only if necessary for managing or processing claims. I am responsible to notify Brethren Benefit Trust of any changes in the above information.

_____ _____
Signature of Active, Inactive, or Retired Employee *Date*

_____ _____
Signature of Spouse of Active, Inactive, or Retired Employee (if enrolling) *Date*