Ministers’ Group includes any employee working 20 or more hours per week at a Church of the Brethren-affiliated church, district, or camp.

Welcome to Church of the Brethren Insurance Services! We look forward to providing the insurance coverage you want with Brethren values you trust.

It is important that your completed enrollment forms are returned to Brethren Insurance Services within 31 days of your hire date, or you will need to wait for the next open enrollment period. Late enrollment for life and/or disability may be possible by going through underwriting with the carrier.

After the forms are filled out, give them to your employer for review and signatures. Completed forms need to be sent to Brethren Benefit Trust’s office in Elgin, Ill. Please do not send payment along with your enrollment forms. Once your enrollment has been approved, we will send an invoice for the premiums due.

Listed below are the forms you need to complete in order to start your insurance coverage. Please read and complete each form carefully. You will note that there is an employer signature line on some of the forms. It is important that each form is completed with the appropriate signature(s).

1. Insurance Enrollment Information - Complete this form and select insurance options accordingly.
2. Dental - Review the summary of benefits, select the option you wish to enroll in, and fill out the enrollment form accordingly.
3. Vision - Review the summary of benefits, select the option you wish to enroll in, and fill out the enrollment form accordingly.
4. Life and Disability - Basic Life, Accidental Death and Dismemberment, Dependent Life, Supplemental Life and AD&D, Long-Term and Short-Term Disability are being offered during open enrollment. Select the desired coverage and complete the Insurance Enrollment Information form accordingly. If you wish to enroll in Supplemental Life, LTD, and/or STD, you must fill out additional forms as indicated below and complete the Designation of Beneficiary form.
5. Supplemental and Dependent Life - You must enroll in Basic Life insurance to be eligible for Supplemental Life insurance. Supplemental Life is available to the employee, their spouse, and their dependent children. See Supplemental Life enrollment form for specific coverage details, and complete the Designation of Beneficiary form.
6. Long-Term Disability Budget Worksheet - This form must be filled out upon initial enrollment, annually, and every time there is a salary/housing change. Your salary (plus any housing allowance including utilities) equals your coverage amount. To ensure that you have the right amount of coverage, we must be informed each time your salary changes.
7. Short-Term Disability Budget Worksheet - This form must be filled out upon initial enrollment, annually, and every time there is a salary/housing change. Your salary (plus any housing allowance including utilities) equals your coverage amount. To ensure that you have the right amount of coverage, we must be informed each time your salary changes.
8. Accident Insurance - You may choose among three plan options. Review the enclosed summary of benefits and complete the enrollment form to enroll.
9. Pet Insurance - Choose between two levels of coverage. All rates are based on pet species (cat, dog, etc.) and location of residence.
10. Election Form and Salary Reduction Agreement - Through Brethren Flexcare you are able to have your employer withhold your share of the premiums on a pre-tax basis. See the Election Form instructions for guidelines to fill out this form.
11. Medicare Supplement - Review the summary of benefits, select the option you wish to enroll in, and fill out the enrollment form accordingly.
12. Authorization Agreement for Automatic Payment - This form should be completed by the employer for payment of insurance premiums.
13. Rate Sheets - Review the rate sheets to determine the premiums for the insurance coverage you have elected.

In the future, if you wish to make changes in the application information (name, beneficiary, etc.), contact the insurance member services representative at 800-746-1505 or insurance@cobbt.org.
Eligibility
Brethren Insurance Services, a not-for-profit ministry of Church of the Brethren Benefit Trust Inc., exists to provide health and welfare benefits to Church of the Brethren-affiliated organizations and other persons and groups that share similar values.

What we offer
Brethren Insurance Services provides comprehensive health and welfare benefits designed to meet your unique needs. These services include dental, vision, life, accidental death and dismemberment, long-term disability, short-term disability, Medicare supplement, accident, pet, and long-term care insurance.

Basic Eligibility Guidelines
Brethren Insurance Services offers group insurance for employees of churches, districts, and camps who work at least 20 hours per week and enroll within 31 days of their hire date or during annual open enrollment. Special open enrollment is available within 31 days of a qualifying event such as the birth or adoption of a child, marriage or divorce, or loss of other coverage.

Upon termination of employment, coverage ends on the last date of employment as communicated to Brethren Insurance Services by the respective employer group representative.

Dental and Vision
Brethren Insurance Services offers group dental and vision insurance for employees of churches, districts, and camps who work at least 20 hours per week and enroll within 31 days of their hire date or during annual open enrollment. Dental and vision insurance ends on the last day of employment. No continuation or conversion privileges are available. To avoid anti-selection against the dental and/or vision plan, once a Plan member elects to enroll in the dental and/or vision plan, they must remain enrolled for a 12-month period as detailed on the enrollment form completed at the time of enrollment. If coverage is cancelled, it cannot be elected again for a 24-month period. Termination of employment will override this policy.

Life, AD&D, LTD, STD
Brethren Insurance Services offers group life, accidental death and dismemberment, and short-term and long-term disability insurance for employees of churches, districts, and camps who work at least 20 hours per week and enroll within 31 days of their hire date or during a special open enrollment when offered. The possibility of late enrollment is offered after completing and submitting an Evidence of Insurability form, which is sent to underwriting for a determination of approval or denial of late enrollment.

Upon termination of employment, coverage ends on the last date of employment as communicated to Brethren Insurance Services by the respective employer group representative.

The life insurance carrier offers an option to port or convert the policy to an individual policy. More information about these options is available by contacting your member services representative. Upon retirement, coverage ends on the date of retirement.
Brethren Insurance Services offers Brethren FlexCare, which allows the employer to withhold the employee’s share of the premiums for basic life, dental, and vision on a pre-tax basis.

Accident
Accident insurance complements important protection like medical and disability insurance. It pays a fixed, lump-sum benefit for injuries resulting from a covered accident — up to and including death (if your employer’s plan includes that provision). There are three options available, and benefits are paid directly to you or your designee.

Medicare Supplement Plan Eligibility
Medicare Supplement insurance is available to active and retired Medicare-eligible employees of a participating employer.

Actives
“Actives” are Medicare-eligible employees who work 20 or more hours per week at a participating employer with less than 20 employees, as well as their Medicare-eligible spouses. At the time the individual becomes eligible for Medicare, that person must enroll in Medicare Part A and Part B as his or her primary coverage and enroll in this plan within the six-month enrollment period that immediately follows that person’s Medicare eligibility date. Premiums are billed to the employer.

Retirees
“Retirees” are Medicare-eligible retirees of a Church of the Brethren-affiliated employer and their Medicare-eligible spouses, widows, or widowers. At the time that the individual becomes eligible for Medicare, that person must enroll in Medicare Part A and Part B as his or her primary coverage and enroll in this plan within the six-month enrollment period that immediately follows that person’s Medicare eligibility date. The retiree is on an individual policy and premiums are billed directly to the retiree.

Pet
Pet Insurance is available at anytime — not just during Open Enrollment. Coverage is available for your pets, regardless of age. The rates are based on the species of pet and the state of residence. See www.petinsurance.com/cobbt for more details.

Long-Term Care — Available anytime, not just during initial enrollment.
Brethren Insurance Services offers Long-Term Care Insurance to all members of the Church of the Brethren; employees of Church of the Brethren-affiliated agencies, organizations, colleges, and retirement communities; and their family and friends.

Long-term care insurance can pay for services associated with a prolonged physical illness, a degenerative disease like Alzheimer’s or Parkinson’s, or a disability. Currently, BBT provides policies with six of A.M. Best’s A-rated insurance companies — Genworth Financial, John Hancock Life Insurance, Lincoln Financial Group, Mass Mutual, Mutual of Omaha, and Transamerica Life Insurance Companies.
Brethren Insurance Services
Enrollment Process

Basic Enrollment/Disenrollment Procedures
1. Ensure that the eligibility guidelines have been met in accordance with the eligibility
2. Within the first 31 days of eligibility, complete an appropriate enrollment form for each line
   of coverage desired.
3. Submit the forms to Brethren Insurance Services at 1505 Dundee Ave., Elgin, IL 60120, fax to
   847-742-6336, or email to insurance@cobbt.org.
4. Coverage may be cancelled in accordance with the Plan booklet and with written
   authorization from the Plan member through the completion of a cancellation form.

Open Enrollment Procedures
1. Open enrollment is available annually for the dental, vision, life, LTD, STD, and accident plans.
2. Open enrollment is conducted in November each year.
3. Ensure that the eligibility guidelines have been met in accordance with the eligibility
4. Complete an appropriate enrollment form for each line of coverage desired.
5. Submit the enrollment form to Brethren Insurance Services at 1505 Dundee Ave, Elgin, IL
   60120, fax to 847-742-6336, or email to insurance@cobbt.org.

Special Enrollment Procedures
1. Special enrollment is available within 31 days of a qualifying event, such as the birth or
   adoption of child, marriage or divorce, or loss of other coverage.
2. Ensure that the eligibility guidelines have been met in accordance with the eligibility
3. Complete an appropriate enrollment form for each line of coverage desired.
4. Submit the enrollment form to Brethren Insurance Services at 1505 Dundee Ave, Elgin, IL
   60120, fax to 847-742-6336, or email to insurance@cobbt.org.

Late Enrollment Procedures
1. Late enrollment is only available for life, AD&D, and disability coverage.
2. Ensure that the eligibility guidelines have been met in accordance with the eligibility
3. Complete an Evidence of Insurability form.
4. Submit the late enrollment form to Brethren Insurance Services at 1505 Dundee Ave, Elgin, IL
   60120, fax to 847-742-6336, or email to insurance@cobbt.org.
5. Brethren Insurance Services will notify you when the coverage has been approved or denied
   for late enrollment.
6. If approved, complete an appropriate enrollment form for each approved line of coverage
   within 31 days of approval.
7. Submit the enrollment form to Brethren Insurance Services at 1505 Dundee Ave, Elgin, IL
   60120, fax to 847-742-6336, or email to insurance@cobbt.org.
Brethren Insurance Services
Ancillary Plans
Overview

**Dental**
- Group coverage is offered through the Delta Dental PPO network.
- BBT currently offers the employer a choice of three different plan designs.
- The plans will pay appropriate usual and customary charges for routine services and supplies that are authorized by a dentist, including —
  - 100 percent of preventive services.
  - 80 percent of restorative services.
  - 50 percent of major services.
  - 50 percent of orthodontia services for dependent children under age 19.
- Plans range from no deductible to $50 single/$150 family.
- All plans include orthodontia coverage.
- Delta To-Go benefit is included, which offers a carryover of the annual maximum to the next year, although some limits apply.

**Vision**
- Group coverage is offered through EyeMed Vision Care using the Select PPO network.
- BBT currently offers the employer a choice of three different plan designs that include the following —
  - Minimal copayment for annual eye exam.
  - Minimal copayment for single, bifocal, or trifocal lenses annually.
  - Generous allowances for contact lenses (in lieu of eyeglass lenses).
  - Generous allowances for frames, annually or every 24 months.
  - No deductible.

**Basic Life and Accidental Death and Dismemberment**
- The amount of Basic Life is determined by age and status.
- Under age 65 (active employee) — $50,000.
- Age 65 and over (active employee) — $26,000.
Supplemental Life, Dependent Life, and Accidental Death and Dismemberment

- **Employee:** An amount up to 5 times your salary (rounded to the nearest $10,000)
  - Guaranteed issue: $300,000
  - Maximum coverage with evidence of insurability: $400,000

- **Spouse:** An amount up to the equivalent of one-half of the employee coverage amount
  - Guaranteed issue: $40,000
  - Maximum coverage with evidence of insurability: $150,000

- **Dependent Child:** $10,000 or $20,000. The rate is the same no matter how many children are covered. (Student verification form required for each child age 20 to 26.)
  - Guaranteed issue: $20,000
  - Maximum coverage: $20,000

Long-Term Disability

- Long-Term Disability gives your employees the security of continued income in the event of an accident, illness, or injury that prevents them from fulfilling their work obligations.
- The plan covers 66⅔ percent of salary up to $5,000 per month, reduced by Social Security or other group disability benefits, with a minimum monthly benefit of $100.
- Payments will begin after three months (90 days) of continuous disability and can continue up to age 65.
- The coverage includes a catastrophic disability component.
- 3/12 pre-existing period — Any sickness or injury for which you received medical treatment, consultation, care, or services — including diagnostic procedures — or took prescribed drugs or medicines to treat during the three months immediately prior to your effective date of insurance is not covered for the first 12 months the policy is in effect.

- Additional services provide added value at no cost —
  - Travel assistance through On Call International.
  - Employee assistance program through ACI Specialty Benefits.

Short-Term Disability

- Minimum salary requirement: $15,000.
- Short-Term Disability gives employees the option to insure 60 percent of their weekly income for up to 11 weeks.
- Benefits will begin after 14 days of disability.
- The maximum weekly benefit is $1,250, which covers a salary of $2,083.
- Maternity benefits are included.
- The plan offers very competitive rates while providing coverage for minimal monthly cost.
- 3/12 pre-existing period — Any sickness or injury for which you received medical treatment, consultation, care, or services — including diagnostic procedures — or took prescribed drugs or medicines to treat during the three months immediately prior to your effective date of insurance is not covered for the first 12 months the policy is in effect.
**Accident**
- Complements important protection like medical and disability insurance.
- Pays a fixed, lump-sum benefit for injuries resulting from a covered accident — up to and including death (if your employer’s plan includes that provision).
- Benefits are paid directly to you or your designee.
- Three options available.

**Pet**
- Available anytime, not just during Open Enrollment.
- Coverage is available for your pets, regardless of age.
- Rates are based on species of pet and state of residence.
- See [www.petinsurance.com/cobbt](http://www.petinsurance.com/cobbt) for more details.

**Long-Term Care — Available anytime, not just during open enrollment.**
- Long-term care insurance can pay for services associated with a prolonged physical illness, a degenerative disease like Alzheimer’s or Parkinson’s, or a disability. Currently, BBT provides policies with top-rated insurance companies — Genworth Financial, John Hancock Life Insurance, Life Secure, Mass Mutual, Mutual of Omaha, National Guardian Life, and Transamerica Life Insurance Companies.
- Hybrid Life/Long-term care insurance provided by —
  - Lincoln Financial Group
  - Nationwide
  - One American
- Life Insurance with Long-Term Care rider —
  - John Hancock
  - Mutual of Omaha
  - Nationwide
  - Protective Life
  - Transamerica
Insurance premiums are billed in advance of the month of coverage. For example, for July coverage, the premium invoice is mailed on June 20 and is due on July 1.

Premiums are billed in monthly increments in a list bill format by employee and by line of coverage.

Premium payments are accepted in two convenient formats —

- Via electronic funds transfer. Complete a one-time Authorization for Automatic Payment and we’ll take care of the rest. No checks, no worries, and no stamps to buy with this free and convenient service.
- Via check made payable to Brethren Insurance Services and mailed to our bank lockbox at 24934 Network Place, Chicago, IL 60673.

First of each month — Premiums are due. See our delinquency policy for more information.

15th of each month — Cut-off date for new data to appear on the following month’s invoice. Any enrollment or termination information that is not received by the 15th of the month will appear as an adjustment on the subsequent month’s invoice.

20th of each month — Premium invoices are mailed. In the event that the 20th falls on a weekend or holiday, invoices will be mailed on the preceding business day.

Premiums are billed in full-month increments. No prorating is offered for partial months of coverage.

Coverage is effective on the employee’s eligibility date.

If an employee begins coverage on the first day of the month, the entire month’s premium is billed. Conversely, if an employee terminates coverage on the first day of the month, the entire month’s premium is waived.

If an employee begins coverage on the second day of the month or any day thereafter in the month, that month’s premium is waived, and billing will begin on the first of the following month. Conversely, if an employee terminates coverage on the second day of the month or any day thereafter in the month, the entire month’s premium is due.
Brethren Benefit Trust
Past Due Policy for Brethren Insurance Services

1. Premiums are due on the first of each month for which coverage is billed.

2. If the premium is not received by the 10th of the month, a PAST DUE REMINDER may be emailed to the employer, employee, or retiree.

3. If the premium is not received by the 20th of the month, a PAST DUE NOTICE is mailed to the employer, employee, or retiree. A follow-up phone call is placed to the employer, employee, or retiree.

4. If the premium is not received by the first day of the following month, a CANCELLATION NOTICE is mailed to the employer, employee, or retiree. Cancellation will be retroactive to the first of the month for which premiums were unpaid. Any claims paid during the period of non-payment will be reversed based on the retroactive cancellation date.

5. If the premium is not received by the last day of the following month, a CANCELLATION LETTER is sent via certified mail with return receipt requested to the employer, employee, or retiree. The cancellation is retroactive to the first of the month for which premiums were unpaid. Any claims paid during the period of non-payment will be reversed based on the retroactive cancellation date.

6. The CANCELLATION letter states the reinstatement policy, which is —

   “Upon cancellation, you may reinstate your insurance coverage by paying the past due and current month’s premiums in full, plus a reinstatement fee of 2 percent of the past due premium (with a minimum of $50.00). You may be reinstated if the above fees are received by Brethren Insurance Services on or before the 60th day past the premium due date. You are only allowed to access the reinstatement option once. A second cancellation due to non-payment would require reapplication or late enrollment. This will result in a break in coverage and new rates with an effective date for the new coverage to be determined. Additionally, upon reapplication you will be required to pay all past unpaid premiums and future insurance premiums through electronic funds transfer.”
Your Dedicated Team
Brethren Insurance Services

Brethren Insurance Services
1505 Dundee Ave., Elgin, IL 60120
Toll Free: 800-746-1505
Local: 847-695-0200
Fax: 847-742-6336
E-mail: insurance@cobbt.org ● Website: www.bbtinsurance.org
Hours: Monday – Friday, 8 a.m. – 4 p.m. CST

Jeremiah Thompson — Director of Insurance Operations
Extension: 3368
Direct line: 847-622-3368
jthompson@cobbt.org
- Day-to-day plan administration
- Implementation of products and services
- Open enrollment coordination
- Resolution of eligibility, claims, and billing issues
- Benefit design changes
- Renewals

Connie Sandman — Insurance Plans Specialist
Extension: 3366
Direct line: 847-622-3366
csandman@cobbt.org
- Inquiries and customer service
- Membership additions, deletions, and changes
- Claims and billing questions

Lynnae Rodeffer — Director of Employee Benefits
Extension: 3383
Direct line: 847-622-3383
lrodeffer@cobbt.org
- Overall accountability for relationship
- Strategic and business planning
- Introduction of products and services
- Client visits
- New business

It is our privilege to serve you!
# Voluntary Dental Insurance Triple Option Plan

<table>
<thead>
<tr>
<th></th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductibles</strong></td>
<td>Delta Dental PPO</td>
<td>Delta Premier</td>
<td><strong>Non-Network</strong></td>
</tr>
<tr>
<td>• Individual</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>• Family</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Maximum Annual Benefit per Insured</strong></td>
<td><strong>$2,000</strong></td>
<td><strong>$1,500</strong></td>
<td><strong>$1,000</strong></td>
</tr>
<tr>
<td>Dependent Age Limit</td>
<td>Up to age 26</td>
<td>Up to age 26</td>
<td>Up to age 26</td>
</tr>
<tr>
<td>New Hire Waiting Period</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Late Entrant Waiting Period</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Covered Expenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Preventive Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Deductible Waived</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral Exams (two per calendar year)</td>
<td>100%*</td>
<td>100%*</td>
<td>100%*</td>
</tr>
<tr>
<td>Cleanings (two per calendar year)</td>
<td>100%*</td>
<td>100%*</td>
<td>100%*</td>
</tr>
<tr>
<td>X-Rays</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space Maintainers to age 19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fluoride Treatments to age 18</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants to age 15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Basic Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fillings</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Extractions</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Endodontics (root canal)</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Non-Surgical Periodontics (gum treatment)</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>• Major Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Periodontics (gum treatment)</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Inlays and Onlays</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Crowns</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Dentures</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Bridges</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Implants</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>• Orthodontia (Child Only to age 19)</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

**Non-Network services are subject to U&C/R&C limitations. The Patient will be responsible for any charges over these limits.**

This summary is intended to highlight your benefits and should not be relied on to fully determine coverage. Please refer to your certificate of coverage for a complete outline of covered services, limitations, and exclusions. Benefits are subject to change based on local and state mandated laws.

Benefit information listed in your carrier certificate always supersedes any information provided in this benefit summary.

Revised 10/2019
ENROLLMENT/CHANGE OF STATUS/WAIVER FORM

PLEASE KEEP A COPY FOR YOUR FILES.
Please note that completing this form does not guarantee coverage.

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.

### ALL GROUPS MUST COMPLETE THIS SECTION

**Note: Incomplete forms will be returned.**

- Delta Dental Group Number: 10989
- Church Code (if applicable):
- Hourly: 
- Salaried: 
- Effective Date:  
- Date of Hire: OR Date of Rehire:  
- Name of Employer:  
- Annual Salary:  

### ALL ENROLLEES MUST COMPLETE THE FOLLOWING SECTIONS

Please check one of the options below.

- Yes, I want to enroll in the dental plan offered by Delta Dental of Illinois. (Please select an option below.)
  - Delta Dental PPO/Delta Dental Premier  
  - Option 1  
  - Option 2  
  - Option 3  

- Social Security Number:  
- Employee's Name:  
- First Name:  
- MI:  
- Last Name:  

- Mailing Address:  
- Street:  
- City:  
- State:  
- ZIP:  

- Phone Number:  
- Marital Status:  
- S  
- M  
- Other  
- Date of Birth:  
- Male:  
- Female:  

### REASON FOR SUBMITTING THIS FORM

- Reinstatement Due to Qualifying Event?  
- Yes  
- No  
- If yes, please describe:  

- Open Enrollment:  
- New Employee:  
- Reinstatement:  
- Change:  
- If this is a change, what is the reason?:  

- Address Change:  
- Termination:  
- (Reason:  
- Termination Date:  
- Date of Event:  

- Add Dependent Coverage (List Dependents below)*  
- (Reason:  
- Date of Event:  

- Drop Dependent Coverage (List Dependents below)*  
- (Reason:  
- Date of Event:  

*If you are adding or dropping a dependent due to a qualifying event, please describe:  

- Name Change (Former Name:  

### COVERAGE DESIRED

- Employee Only  
- Employee & Spouse  
- Employee & One Child  
- Employee & Children  
- Entire Family  

- Effective Date:  
- Does spouse have a dental plan?  
- Yes  
- No  
- Are dependents covered by spouses plan?  
- Yes  
- No  

- Spouse's Employer:  
- Spouse's Carrier:  

### PLEASE LIST ALL ELIGIBLE DEPENDENTS TO BE COVERED (Child up to age 26)

<table>
<thead>
<tr>
<th>ADD</th>
<th>DELETE</th>
<th>FIRST NAME</th>
<th>LAST NAME (if different)</th>
<th>BIRTH DATE (M/D/Y)</th>
<th>SEX (M or F)</th>
<th>SSN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1. Spouse:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Child:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I agree to continue enrollment until canceled due to IRS-qualifying event or canceled by me during annual open enrollment. I further authorize applicable payroll deduction, where available, for premiums due.

Signature of Employee: ___________________________  Date: ___________________________

Signature of Employer: ___________________________  Date: ___________________________

Delta Dental of Illinois

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
## Summary of Benefits - Vision

### Voluntary Vision Insurance Triple Option Plan

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EyeMed Member Doctor</td>
<td>Non-EyeMed Member Doctor</td>
<td>EyeMed Member Doctor</td>
</tr>
<tr>
<td><strong>Examinations</strong></td>
<td>Once every 12 months</td>
<td>Once every 12 months</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td><strong>Lenses</strong></td>
<td>Once every 12 months</td>
<td>Once every 12 months</td>
<td>Once every 12 months</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td>Once every 24 months</td>
<td>Once every 24 months</td>
<td>Once every 24 months</td>
</tr>
</tbody>
</table>

### Benefits

<table>
<thead>
<tr>
<th>Item</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Examination</strong></td>
<td>$10 copay, up to $35</td>
<td>$10 copay, up to $35</td>
<td>$10 copay, up to $35</td>
</tr>
<tr>
<td><strong>Single Vision Lenses</strong></td>
<td>$25 copay, up to $25</td>
<td>$25 copay, up to $25</td>
<td>$10 copay, up to $25</td>
</tr>
<tr>
<td><strong>Bifocal Lenses</strong></td>
<td>$25 copay, up to $40</td>
<td>$25 copay, up to $40</td>
<td>$10 copay, up to $40</td>
</tr>
<tr>
<td><strong>Trifocal Lenses</strong></td>
<td>$25 copay, up to $60</td>
<td>$25 copay, up to $60</td>
<td>$10 copay, up to $60</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td>$120 allowance, then 20% discount, up to $48</td>
<td>$100 allowance, then 20% discount, up to $40</td>
<td>$140 allowance, then 20% discount, up to $56</td>
</tr>
<tr>
<td><strong>Lens Options</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UV Coating</td>
<td>20% discount</td>
<td>N/A</td>
<td>20% discount</td>
</tr>
<tr>
<td>Tint (solid and gradient)</td>
<td>20% discount</td>
<td>N/A</td>
<td>20% discount</td>
</tr>
<tr>
<td>Standard Scratch Resistant</td>
<td>20% discount</td>
<td>N/A</td>
<td>20% discount</td>
</tr>
<tr>
<td>Standard Polycarbonate</td>
<td>20% discount</td>
<td>N/A</td>
<td>20% discount</td>
</tr>
<tr>
<td>Standard Progressive (bi-focal)</td>
<td>$25 copay, then 80% of charge less $55 allowance, up to $40</td>
<td>$25 copay, then 80% of charge less $55 allowance, up to $40</td>
<td>$10 copay, then 80% of charge less $120 allowance, up to $85</td>
</tr>
<tr>
<td>Standard Anti-Reflective Coating</td>
<td>20% discount</td>
<td>N/A</td>
<td>20% discount</td>
</tr>
<tr>
<td>Other Add-Ons and Services</td>
<td>20% discount</td>
<td>N/A</td>
<td>20% discount</td>
</tr>
<tr>
<td><strong>Contact Lenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conventional</td>
<td>up to $135 then 15% discount</td>
<td>up to $95</td>
<td>up to $115 then 15% discount</td>
</tr>
<tr>
<td>Disposable</td>
<td>up to $135</td>
<td>up to $95</td>
<td>up to $115</td>
</tr>
<tr>
<td><strong>LASIK Surgery</strong></td>
<td>5% to 15% discount</td>
<td>N/A</td>
<td>5% to 15% discount</td>
</tr>
<tr>
<td><strong>Dependent Age Limit</strong></td>
<td>Up to age 26</td>
<td>Up to age 26</td>
<td>Up to age 26</td>
</tr>
</tbody>
</table>

*Service Restriction: Plan allows the member to receive either contacts and frame, or frame and lens services.*

This summary is intended to highlight your benefits and should not be relied on to fully determine coverage. Please refer to your certificate of coverage for a complete outline of covered services, limitations, and exclusions. Benefits are subject to change based on local and state mandated laws. Benefit information listed in your carrier certificate always supersedes any information provided in this benefit summary.
**Enrollment/Change Form**

*Please print and complete all sections. See instructions below.*

Underwritten by Fidelity Security Life Insurance Company of Kansas City, Missouri

---

**EMPLOYER INFORMATION:**

<table>
<thead>
<tr>
<th>Group Number</th>
<th>Employer Name</th>
<th>Plan Selection</th>
<th>Hire Date</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>9729526</td>
<td></td>
<td>Option 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Option 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Option 3</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EMPLOYEE INFORMATION**

- **ADD**
- **TERM**
- **CHG**

<table>
<thead>
<tr>
<th>Sex</th>
<th>Member ID (SSN)</th>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Member ID (SSN)</th>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**FAMILY INFORMATION** (Only those eligible may be enrolled.)

- **A**: Add (enroll)
- **T**: Terminate
- **C**: Change (change of name)

<table>
<thead>
<tr>
<th>Sex</th>
<th>Last Name (spouse)</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Last Name (dependent)</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Last Name (dependent)</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Last Name (dependent)</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

I agree to continue enrollment until canceled due to IRS-qualifying event or canceled by me during annual open enrollment. I further authorize applicable payroll deduction, where available, for premiums due.

Employee Signature: ___________________________ Date: ____________

Employer Signature: ___________________________ Date: ____________

---

**Instructions:**

**Effective date:** The day you become eligible.

**Family Information:** List only eligible family members who are enrolling. Dependent eligibility is up to age 26.

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.
Insurance Enrollment Information (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.

**TO BE COMPLETED BY EMPLOYEE**

Employee Last Name________________________________________ First Name________________________________ MI___________

Employee Address____________________________________________________________________________________________________

City ____________________________________ State___________ ZIP _______________ Phone _____________________

Birth Date__________________________ Social Security Number_______________________________ Gender: q Male  q Female

Marital Status: q Single  q Married  Email____________________________________________________________________

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

**TO BE COMPLETED BY EMPLOYER**

Employer or Congregation Name_______________________________________________________________

Employer Address____________________________________________________________________________

City ______________________________________ State_______________ ZIP _____________ Phone____________________________________________

Contact Person______________________________________________________Phone____________________________________________

Email______________________________________________________________ q Check here if you wish to receive your invoice via email.

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

EMPLOYEE INFORMATION

Job Title_______________________________________________ Hours Worked/Week___________Annual Earnings $________________

Date of hire per contract___________________________________ Employment Status: Ordained Licensed Lay Employee

ENROLLMENT

Eligibility requirement: Must be actively employed and working 20 hours or more per week.

Check the boxes of the plan(s) you wish to enroll in.

- Basic Life and AD&D $50,000 Coverage ($26,000 for age 65+)
  (Complete Beneficiary form.)
- Supplemental Life
  Employee Spouse Child
  (Employee must enroll in Basic Life, fill out the Supplemental Life Enrollment form, AND complete the Beneficiary form.)
- Dental
  (Fill out Dental Enrollment form.)
- Vision
  (Fill out Vision Enrollment form.)
- Accident
  (Fill out Accident form)
- Long-Term Disability
  Short-Term Disability
  (Fill out LTD and/or STD Budget Worksheet now and annually)

Effective Date of Coverage: ______________________

**SIGNATURES**

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 authorize deductions from my earnings to serve as payment for any required contributions. 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

(Chair board chair, district executive, treasurer, or other authorized employer representative)
Designation of Beneficiary

Basic and Supplemental Life Insurance

Policyholder Name: Church of the Brethren Benefit Trust Inc.
Policy Number: GL145627

Insured Name: __________________________
Social Security Number: __________________________

Address: __________________________
City: __________________________
State: ______
ZIP: ___________

Phone Number: __________________________
Email: __________________________

I hereby designate the following as my beneficiary(ies) under the above policy number:

**Primary Beneficiary(ies)**

<table>
<thead>
<tr>
<th>Full Name and Address</th>
<th>Percentage* (must total 100%)</th>
<th>Date of Birth</th>
<th>Relationship</th>
<th>Social Security Number</th>
<th>Email Address and Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*If no percentages are indicated, benefits will be divided equally among all primary beneficiaries.

**Contingent Beneficiary(ies) (applicable only if you are not survived by one or more primary beneficiaries)**

<table>
<thead>
<tr>
<th>Full Name and Address</th>
<th>Percentage* (must total 100%)</th>
<th>Date of Birth</th>
<th>Relationship</th>
<th>Social Security Number</th>
<th>Email Address and Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*If no percentages are indicated, any benefits payable to contingent beneficiaries will be divided equally among all contingent beneficiaries.

- This beneficiary designation revokes all revocable prior beneficiary designations.
- Unless you indicate otherwise, if any beneficiary predeceases you, that beneficiary’s share will be divided pro-rata among the surviving beneficiaries of the same class (primary or contingent).
- If additional space is needed, please attach a separate piece of paper with signature and date.

Signature of insured: __________________________
Date: __________________________

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

*(Please complete a beneficiary form for each insured employee, spouse, and child, if applicable.)*

*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

A not-for-profit ministry of Church of the Brethren Benefit Trust Inc.
Supplemental Life Insurance Enrollment

Employee must be enrolled in Basic Life to be eligible. Supplemental Life insurance may not be paid with pre-tax premiums.

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.

Please follow these guidelines when filling out Supplemental Life Enrollment Form —

In increments of $10,000

Guaranteed issue: $300,000

Maximum coverage with evidence of insurability: $400,000. Additional form required.

Spouse: An amount up to the equivalent of one-half of the employee coverage amount in increments of $10,000

Guaranteed issue: $40,000

Maximum coverage with evidence of insurability: $150,000. Additional form required.

Dependent Child: $10,000 or $20,000. The rate is the same no matter how many children are covered. (Student verification form required for each child age 20 to 26 — see next page.)

Guaranteed issue: $20,000

Maximum coverage: $20,000

Supplemental Life Insurance

NOTE: Employee is required to be enrolled in Basic Life (but not Supplemental Life) for all additions below.

Check the boxes of the plan(s) you wish to enroll in: Q Employee Q Spouse Q Dependent Child

Policyholder Name Church of the Brethren Benefit Trust Inc.

Employer Name ___________________________ Church of the Brethren Benefit Trust Inc.

Employee Salary ___________________________

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

Effective Date of Coverage ___________________________

For Office Use Only

Effective Date of Coverage ___________________________

Signature of Employee ___________________________ Date ________________

Signature of Employer ___________________________ Date ________________

Revised 10/2019

I hereby apply for Supplemental Life insurance to which I am entitled or to which I may become entitled under the provisions of the group policy or policies issued by Reliance Standard Life Insurance and authorize deductions from my earnings of the required contribution, if any, toward the cost of the insurance.

I understand that if I apply for Supplemental Life insurance after 31 days from the date of eligibility, I will have to furnish at my own expense evidence of my insurability satisfactory to the insurance company before insurance can become effective. Brethren Insurance Services reserves the right to adjust submitted coverage amount if the stated guidelines are not followed.

I UNDERSTAND THAT FUTURE CHANGES IN MY INSURANCE, BECAUSE OF SALARY INCREASES, WILL HAVE TO BE REQUESTED BY ME, IN WRITING, TO MY EMPLOYER.
After age 20, life insurance coverage for a dependent child may continue up to age 26 if that child is **unmarried** and enrolled as a full-time student at a college or other school. The child must also be financially dependent on the Primary Plan Member for support.

Please use this form to verify your child’s student status. Brethren Insurance Services is required to verify eligibility each semester using the information on this form. Failure to provide complete and accurate information may result in cancellation of coverage. Send the completed form to —

**Brethren Insurance Services, 1505 Dundee Ave, Elgin, IL 60120**
Fax: 847-742-6336
insurance@cobbt.org

If you have any questions, please contact **Connie Sandman** at **800-746-1505, ext. 3366**.

### Student Verification Information

- **☐** Dependent Child is not a full-time student. Date member was no longer a student: ______________________
  (Coverage will be terminated according to the terms of the group contract.)

- **☐** Dependent Child is a full-time student at a college or other school:
  
  Dependent Child is:  **☐** Single  **☐** Married

  Eligible Dependent Name (Student) __________________________________________ Date of Birth__________________

  Name of College or Other School: __________________________________________ Date Current Semester Began__________________

  Address of College or Other School: ________________________________________

  No. of Hours Enrolled _______ Graduation Date (if known) ___________ Phone No. of College or Other School__________

  Primary Plan Member Signature ____________________________________________ Date:________________________
Please keep a completed copy for your records.

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.

**ACCOUNT INFORMATION**

Employer or Congregation Name __________________________________________ Agreement No. or Church Code ____________

Employee Last Name__________________________________________ First Name ____________________________________ MI ______

Employee Address ____________________________________________________________________________________________________

City_______________________________________________State_____________________________ ZIP _____________ -___________

Telephone_________________________________________ Email ________________________________

**LTD PREMIUM CALCULATION**

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

**NOTE:** Coverage amount is based on this information. Please submit a new form annually and any time there is a salary and/or housing allowance change.

Salary Effective Date _______________ Hours worked per week __________________________

(minimum required = 20 hrs/wk)

A. Your base annual cash salary (Do not prorate) ........................................................................................................... A.______________

B. Housing Allowance (includes utilities) ......................................................................................................................... B.______________

(If you use a parsonage, use 20 percent of (A), or rental value of parsonage.)

C. Total (A) + (B) (Maximum covered salary is $90,000) .......................................................................................... C.______________

D. Divide (C) by $100 .................................................................................................................................................. D.______________

E. Multiply (D) by 0.70 (This is your annualized LTD premium) ............................................................................... E.______________

F. Divide (E) by 12 (This is your monthly LTD premium) ......................................................................................... F.______________

**SIGNATURES**

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 authorize deductions from my earnings to serve as payment for any required contributions. 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 ____________

(church board chair, district executive, treasurer, or other authorized employer representative)
2020 Budget Worksheet
Short-Term Disability

Please keep a completed copy for your records.
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.

### ACCOUNT INFORMATION

**Employer or Congregation Name**

**Employee Last Name** __________________________ **First Name** __________________________ **MI** _____________

**Employee Address**

City __________________________ **State** _____________ **ZIP** _____________

**Phone** __________________________ **Email**

---

### STD PREMIUM CALCULATION

Benefit covers 60 percent of weekly earnings (up to $1,250 per week max).

**NOTE:** Coverage amount is based on this information. Please submit a new form annually and any time there is a salary and/or housing allowance change.

**Salary Effective Date** ______________ **Hours worked per week** ______________

- **A.** Your base **annual** cash salary (do not prorate) ______________
- **B.** Housing Allowance (includes utilities)
  - (If you use a parsonage, use 20 percent of (A), or rental value of parsonage.) ______________
- **C.** Total (A) + (B) (must be at least $15,000) (maximum covered salary is $108,316) ______________
- **D.** Divide (C) by 52 (not to exceed $2,083) ______________
- **E.** Multiply (D) by 0.60 ______________
- **F.** Multiply (E) by (rate according to your age bracket in table to the right) ______________
- **G.** Divide the amount on line (F) by 10 (this is your monthly premium) ______________
- **H.** Multiply line (G) by 12 (this is your annualized premium) ______________

### SIGNATURES

I understand that misstatements, misrepresentations, or omissions may result in 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 authorize deductions from my earnings to serve as payment for any required contributions. 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**

(church board chair, district executive, treasurer, or other authorized employer representative) __________________________ **Date** ______________

---

Please keep a completed copy for your records.
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.

### ACCOUNT INFORMATION

**Employer or Congregation Name**

**Employee Last Name** __________________________ **First Name** __________________________ **MI** _____________

**Employee Address**

City __________________________ **State** _____________ **ZIP** _____________

**Phone** __________________________ **Email**

---

### STD PREMIUM CALCULATION

Benefit covers 60 percent of weekly earnings (up to $1,250 per week max).

**NOTE:** Coverage amount is based on this information. Please submit a new form annually and any time there is a salary and/or housing allowance change.

**Salary Effective Date** ______________ **Hours worked per week** ______________

- **A.** Your base **annual** cash salary (do not prorate) ______________
- **B.** Housing Allowance (includes utilities)
  - (If you use a parsonage, use 20 percent of (A), or rental value of parsonage.) ______________
- **C.** Total (A) + (B) (must be at least $15,000) (maximum covered salary is $108,316) ______________
- **D.** Divide (C) by 52 (not to exceed $2,083) ______________
- **E.** Multiply (D) by 0.60 ______________
- **F.** Multiply (E) by (rate according to your age bracket in table to the right) ______________
- **G.** Divide the amount on line (F) by 10 (this is your monthly premium) ______________
- **H.** Multiply line (G) by 12 (this is your annualized premium) ______________

### SIGNATURES

I understand that misstatements, misrepresentations, or omissions may result in 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 authorize deductions from my earnings to serve as payment for any required contributions. 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**

(church board chair, district executive, treasurer, or other authorized employer representative) __________________________ **Date** ______________

---

Please keep a completed copy for your records.
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.

### ACCOUNT INFORMATION

**Employer or Congregation Name**

**Employee Last Name** __________________________ **First Name** __________________________ **MI** _____________

**Employee Address**

City __________________________ **State** _____________ **ZIP** _____________

**Phone** __________________________ **Email**

---

### STD PREMIUM CALCULATION

Benefit covers 60 percent of weekly earnings (up to $1,250 per week max).

**NOTE:** Coverage amount is based on this information. Please submit a new form annually and any time there is a salary and/or housing allowance change.

**Salary Effective Date** ______________ **Hours worked per week** ______________

- **A.** Your base **annual** cash salary (do not prorate) ______________
- **B.** Housing Allowance (includes utilities)
  - (If you use a parsonage, use 20 percent of (A), or rental value of parsonage.) ______________
- **C.** Total (A) + (B) (must be at least $15,000) (maximum covered salary is $108,316) ______________
- **D.** Divide (C) by 52 (not to exceed $2,083) ______________
- **E.** Multiply (D) by 0.60 ______________
- **F.** Multiply (E) by (rate according to your age bracket in table to the right) ______________
- **G.** Divide the amount on line (F) by 10 (this is your monthly premium) ______________
- **H.** Multiply line (G) by 12 (this is your annualized premium) ______________

### SIGNATURES

I understand that misstatements, misrepresentations, or omissions may result in 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 authorize deductions from my earnings to serve as payment for any required contributions. 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**

(church board chair, district executive, treasurer, or other authorized employer representative) __________________________ **Date** ______________

---

Please keep a completed copy for your records.
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.

### ACCOUNT INFORMATION

**Employer or Congregation Name**

**Employee Last Name** __________________________ **First Name** __________________________ **MI** _____________

**Employee Address**

City __________________________ **State** _____________ **ZIP** _____________

**Phone** __________________________ **Email**

---

### STD PREMIUM CALCULATION

Benefit covers 60 percent of weekly earnings (up to $1,250 per week max).

**NOTE:** Coverage amount is based on this information. Please submit a new form annually and any time there is a salary and/or housing allowance change.

**Salary Effective Date** ______________ **Hours worked per week** ______________

- **A.** Your base **annual** cash salary (do not prorate) ______________
- **B.** Housing Allowance (includes utilities)
  - (If you use a parsonage, use 20 percent of (A), or rental value of parsonage.) ______________
- **C.** Total (A) + (B) (must be at least $15,000) (maximum covered salary is $108,316) ______________
- **D.** Divide (C) by 52 (not to exceed $2,083) ______________
- **E.** Multiply (D) by 0.60 ______________
- **F.** Multiply (E) by (rate according to your age bracket in table to the right) ______________
- **G.** Divide the amount on line (F) by 10 (this is your monthly premium) ______________
- **H.** Multiply line (G) by 12 (this is your annualized premium) ______________

### SIGNATURES

I understand that misstatements, misrepresentations, or omissions may result in 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 authorize deductions from my earnings to serve as payment for any required contributions. 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**

(church board chair, district executive, treasurer, or other authorized employer representative) __________________________ **Date** ______________
### ELIGIBILITY

**Employees:** Each Active Full-Time Employee working 20 hours or more per week, except any person working on a temporary or seasonal basis. Employee must be under age 70 to enroll.

**Spouse:** An eligible employee’s legal spouse. Spouse must be under age 70 to enroll.

Civil union partner coverage is automatically included on the plan where required by state law.

**Dependent Children:** An eligible employee’s unmarried child(ren) under 26 years, including adoptive, foster and stepchildren who are financially dependent on the eligible employee for support, or age 30 if an Illinois resident, served as a member of the active or reserve components of any of the branches of the Armed Forces of the US and has received a release or discharge other than a dishonorable discharge; and an eligible employee’s unmarried child(ren) who is both incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who is chiefly dependent on the eligible employee for support and maintenance.

Employee must be insured under the policy for dependent spouse and/or children to be insured. A person may not have coverage as both an employee and a dependent.

Our standard eligibility includes employees who are US citizens working in the US; contact your sales office if you have employees who are not US citizens working in the US, and you’d like us to consider them in the eligibility.

### BENEFIT SCHEDULE

<table>
<thead>
<tr>
<th>All Employees</th>
<th>Eligible to elect Option 1, Option 2, or Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Care Benefits:</strong></td>
<td></td>
</tr>
<tr>
<td>Ambulance Transportation</td>
<td>$100 Ground, $500 Air</td>
</tr>
<tr>
<td>Emergency Treatment</td>
<td>$150</td>
</tr>
<tr>
<td>Diagnostic Examination</td>
<td>$100 per CT/MRI scan</td>
</tr>
<tr>
<td>Initial Physician Office Visit</td>
<td>$50</td>
</tr>
<tr>
<td><strong>General Treatment Benefits:</strong></td>
<td></td>
</tr>
<tr>
<td>Initial Hospital Admission</td>
<td>$500</td>
</tr>
<tr>
<td>Initial ICU Hospital Admission</td>
<td>$1,000</td>
</tr>
<tr>
<td>Hospital Confinement</td>
<td>$200 per day, 365 days maximum</td>
</tr>
<tr>
<td>ICU Confinement</td>
<td>$400 per day, 30 days maximum</td>
</tr>
<tr>
<td>Rehabilitation Facility Confinement</td>
<td>$50 per day, 30 days maximum</td>
</tr>
<tr>
<td>Follow-up Physician Office Visit</td>
<td>$50</td>
</tr>
</tbody>
</table>
### Specified Covered Injury & Treatment Benefits:

<table>
<thead>
<tr>
<th>Category</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transportation</strong></td>
<td>$300, if more than 100 miles from residence</td>
<td>$450, if more than 100 miles from residence</td>
<td>$600, if more than 100 miles from residence</td>
</tr>
<tr>
<td><strong>Lodging</strong></td>
<td>$100 per day up to 30 days if more than 100 miles from residence</td>
<td>$150 per day up to 30 days if more than 100 miles from residence</td>
<td>$200 per day up to 30 days if more than 100 miles from residence</td>
</tr>
<tr>
<td><strong>Blood/Plasma/Platelets</strong></td>
<td>$200</td>
<td>$300</td>
<td>$400</td>
</tr>
<tr>
<td><strong>Burns</strong></td>
<td>To $800 for 2nd degree burns; To $6,400 for 3rd degree burns; Skin Graft - 25% of benefit payable for Burns</td>
<td>To $1,600 for 2nd degree burns; To $12,800 for 3rd degree burns; Skin Graft - 25% of benefit payable for Burns</td>
<td>To $3,200 for 2nd degree burns; To $25,600 for 3rd degree burns; Skin Graft - 25% of benefit payable for Burns</td>
</tr>
<tr>
<td><strong>Coma</strong></td>
<td>$5,000</td>
<td>$7,500</td>
<td>$10,000</td>
</tr>
<tr>
<td><strong>Concussion</strong></td>
<td>$100</td>
<td>$150</td>
<td>$200</td>
</tr>
<tr>
<td><strong>Dental Injury</strong></td>
<td>$150 for Crown; $50 for Extraction</td>
<td>$300 for Crown; $75 for Extraction</td>
<td>$400 for Crown; $100 for Extraction</td>
</tr>
<tr>
<td><strong>Eye Injury</strong></td>
<td>$100 for removal of foreign object, $200 for surgical repair</td>
<td>$150 for removal of foreign object, $300 for surgical repair</td>
<td>$200 for removal of foreign object, $400 for surgical repair</td>
</tr>
<tr>
<td><strong>Lacerations</strong></td>
<td>To $400</td>
<td>To $600</td>
<td>To $800</td>
</tr>
<tr>
<td><strong>Paralysis Benefits</strong></td>
<td>$10,000 quadriplegia; $5,000 paraplegia/hemiplegia</td>
<td>$15,000 quadriplegia; $7,500 paraplegia/hemiplegia</td>
<td>$20,000 quadriplegia; $10,000 paraplegia/hemiplegia</td>
</tr>
<tr>
<td><strong>Surgery Benefits</strong></td>
<td>$100 for Exploratory; $300 for Knee Cartilage; $1,000 for Abdominal or Thoracic; $500 for Ruptured Disc; To $600 Tendon, Ligament, or Rotator cuff</td>
<td>$150 for Exploratory; $450 for Knee Cartilage; $1,500 for Abdominal or Thoracic; $750 for Ruptured Disc; $900 Tendon, Ligament, or Rotator cuff</td>
<td>$200 for Exploratory; $800 for Knee Cartilage; $2,000 for Abdominal or Thoracic; $1,000 for Ruptured Disc; $1,500 Tendon, Ligament, or Rotator cuff</td>
</tr>
<tr>
<td><strong>Transitional Benefit:</strong></td>
<td>Medical Appliances $100</td>
<td>Medical Appliances $150</td>
<td>Medical Appliances $200</td>
</tr>
<tr>
<td></td>
<td>Prosthesis $1,000 for two or more, $500 for one</td>
<td>Prosthesis $1,500 for two or more, $750 for one</td>
<td>Prosthesis $2,000 for two or more, $1,000 for one</td>
</tr>
<tr>
<td></td>
<td>Physical Therapy $25 per session, 6 sessions maximum</td>
<td>Physical Therapy $35 per session, 6 sessions maximum</td>
<td>Physical Therapy $50 per session, 6 sessions maximum</td>
</tr>
</tbody>
</table>

*This summary is intended to highlight your benefits and should not be relied on to fully determine coverage. Please refer to your certificate of coverage for a complete outline of covered services, limitations, and exclusions. Benefits are subject to change based on local and state mandated laws.*

Benefit information listed in your carrier certificate always supersedes any information provided in this benefit summary.
I hereby apply for Accident insurance to which I am entitled or to which I may become entitled under the provisions of the group policy or policies issued by Reliance Standard Life Insurance and authorize deductions from my earnings of the required contribution, if any, toward the cost of the insurance.

I understand that if I apply for Accident insurance after 31 days from the date of eligibility, I will have to furnish at my own expense evidence of my insurability satisfactory to the insurance company before insurance can become effective. Brethren Insurance Services reserves the right to adjust submitted coverage amount if the stated guidelines are not followed.

___________________________________________________________ ______________________________________________________________________________
Employee Signature Date     Authorized Employer Signature Date

1. ENROLLMENT INFORMATION

Employer Name ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ___________________________ ________________
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 Eligibility 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.
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________________________________________________________________________________________________________________

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**
   Q Option 1 Q Option 2 Q Option 3
   If you wish to elect this coverage, enter the employee’s annualized cost of this plan.
   Q Employee Only   Q Employee + One   Q Family   Q No Coverage Elected..................................................C.______________

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

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

We will use your email address solely to communicate with you about Brethren Insurance Services.
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.**
Authorization Agreement for Automatic Payment

I hereby authorize BRETHREN BENEFIT TRUST INC. to withdraw funds on the first business day of each month from this account for payment of insurance premiums.

Bank Name_________________________________________ Phone____________________________________

City________________________________________________ State ___________ ZIP _________________–__________

Routing Number (9 digits)__________________________ Account Number____________________________________

Please attach a voided check for your checking account or a deposit slip for your savings account.

TO BE COMPLETED BY THE PLAN MEMBER OR EMPLOYER

This authority is to remain in full force and effect until BRETHREN BENEFIT TRUST INC. has received written notification from my/our authorized representative of its termination in such manner as to afford BRETHREN BENEFIT TRUST INC. and my bank a reasonable opportunity to act on it.

Retiree Member Last Name_______________________________________ First Name__________________________________ MI_______

Or Employer Name______________________________________________ Employee Name________________________________________

Phone Number____________________________________ Email_____________________________________________________________

☐ Check here if you wish to receive your invoice via email.

When you sign up for automatic payments, your monthly premium will be deducted on the first business day of each month from your bank account.

______________________________________________________________
Signature of Plan Member (or Employer Representative) Date

RETURN THIS FORM VIA —

Mail: Brethren Benefit Trust Inc.,
1505 Dundee Ave., Elgin, IL 60120
Fax: 847-742-6336
Email: insurance@cobbt.org

For Office Use Only

☐ Startup Request or
☐ Change Request

Effective Date:___________________________
Entered by:__________Date:_______________
Verified by:__________Date:_______________
Long-term care for your peace of mind

When John and Helen Wenger of Anderson (Ind.) Church of the Brethren thought about their lifetime accumulations, they wanted to protect their assets while making sound plans for the future.

“We hope to live at a Brethren retirement community like Timbercrest, and long-term care insurance will allow us to do that. As Brethren, we’re called to be good stewards — our relationship with BBT provides that.”

Long-Term Care Insurance is available to all Church of the Brethren employees and members, as well as their families and friends.

Long-Term Care Insurance Information Request

By filling out this form, I understand that a representative from Brethren Insurance Services will contact me about receiving a free, no-obligation Proposal for Long-Term Care Insurance.

Client’s name__________________________________________________Date________________

Address__________________________________________________________City____________State____ZIP__________

Home phone______________________________  Cell phone              _______________________________

Best time to call:    ❑ A.M.    ❑ P.M.  Email______________________________________________

Date of birth______________________  Age________  Height_____________  Weight___________

Married:   ❑ Yes   ❑ No        Tobacco use within last 5 years:   ❑ Yes   ❑ No

Comments:_______________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

Please hand this completed form to the BBT representative or mail it to the address below.

A not-for-profit ministry of Church of the Brethren Benefit Trust

1505 Dundee Ave., Elgin, IL 60120-1619 • website: www.bbtinsurance.org
847-695-0200 • 800-746-1505 toll-free • 847-742-6336 fax • insurance@cobbt.org
To enroll in any of these plans, please ensure that eligibility requirements have been met, complete the appropriate enrollment form, and return to —

Mail: Brethren Benefit Trust, 1505 Dundee Ave., Elgin, IL 60120; Fax: 847-742-6336; or Email: insurance@cobbt.org

<table>
<thead>
<tr>
<th>Delta Dental Plan</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$66.32</td>
<td>$57.13</td>
<td>$53.38</td>
</tr>
<tr>
<td>Employee + One</td>
<td>$119.59</td>
<td>$103.08</td>
<td>$93.98</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$185.27</td>
<td>$158.67</td>
<td>$144.04</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>EyeMed Vision Plan</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$12.45</td>
<td>$12.32</td>
<td>$17.43</td>
</tr>
<tr>
<td>Employee + One</td>
<td>$17.27</td>
<td>$17.02</td>
<td>$26.74</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$22.00</td>
<td>$21.67</td>
<td>$35.93</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Basic Life Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic and AD&amp;D with $50,000 coverage (Employed, under age 65)</td>
</tr>
<tr>
<td>Basic and AD&amp;D with $26,000 coverage (Employed, age 65 or older)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supplemental Life Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplemental Life Insurance is available for the active employee, spouse, and dependent children. Please refer to the Supplemental Life Insurance Rates for detailed age-bracketed premiums.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disability — Long-Term and Short-Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTD rate is 0.70 cents per $100 of eligible salary. STD rate is age-rated per $10 of eligible salary. Please refer to the Long-Term Disability Budget Worksheet or Short-Term Disability Budget Worksheet form to calculate your premium.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Accident Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
</tr>
<tr>
<td>Employee and Spouse</td>
</tr>
<tr>
<td>Employee and Child(ren)</td>
</tr>
<tr>
<td>Employee and Family</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pet Insurance (Rates based on state of residence) Contact BSI for rates for other types of pets</th>
</tr>
</thead>
<tbody>
<tr>
<td>My Pet Protection</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>Cat</td>
</tr>
<tr>
<td>Dog</td>
</tr>
</tbody>
</table>
When you apply for Basic Life insurance through Church of the Brethren Insurance Services, you are eligible to apply for Supplemental Life insurance. Purchasing Supplemental Life insurance is optional for the employee. The employer is not required to pay any portion of the premium. The following Supplemental Life coverage is offered in increments of $10,000:

Please follow these guidelines when filling out Supplemental Life Enrollment Form —

Employee: An amount up to 5 times your salary (rounded to the nearest $10,000)
  Guaranteed issue: $300,000
  Maximum coverage with evidence of insurability: $400,000

Spouse: An amount up to the equivalent of one-half of the employee coverage amount in increments of $10,000
  Guaranteed issue: $40,000
  Maximum coverage with evidence of insurability: $150,000

Dependent Child: $10,000 or $20,000. The rate is the same no matter how many children are covered.
  Guaranteed issue: $20,000
  Maximum coverage: $20,000

2020 Monthly Rates
Supplemental Life Insurance

Your rate will change as you progress through these age brackets. When your Basic Life insurance amount is reduced from $50,000 to $26,000 at age 65, the Supplemental Life amount will also be reduced according to the standard reduction schedule. Please contact Brethren Insurance Services for more details.

Employee and Spouse Supplemental Life and AD&D Monthly Rates

<table>
<thead>
<tr>
<th>Age</th>
<th>per $1,000</th>
<th>per $10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 25</td>
<td>$0.27</td>
<td>$2.70</td>
</tr>
<tr>
<td>25-29</td>
<td>0.27</td>
<td>2.70</td>
</tr>
<tr>
<td>30-34</td>
<td>0.31</td>
<td>3.10</td>
</tr>
<tr>
<td>35-39</td>
<td>0.33</td>
<td>3.30</td>
</tr>
<tr>
<td>40-44</td>
<td>0.38</td>
<td>3.80</td>
</tr>
<tr>
<td>45-49</td>
<td>0.49</td>
<td>4.90</td>
</tr>
<tr>
<td>50-54</td>
<td>0.66</td>
<td>6.60</td>
</tr>
<tr>
<td>55-59</td>
<td>0.93</td>
<td>9.30</td>
</tr>
<tr>
<td>60-64</td>
<td>1.08</td>
<td>10.80</td>
</tr>
<tr>
<td>65-69</td>
<td>1.65</td>
<td>16.50</td>
</tr>
<tr>
<td>70+</td>
<td>2.60</td>
<td>26.00</td>
</tr>
</tbody>
</table>

Dependent Child Life and AD&D Monthly Rates

<table>
<thead>
<tr>
<th>Age</th>
<th>per $1,000</th>
<th>per $10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 mos. - 20 yrs.*</td>
<td>$0.27</td>
<td>$2.70</td>
</tr>
</tbody>
</table>

Employee and Spouse Supplemental Life insurance terminates the earliest of the following:
  • When your Basic Life insurance terminates, or
  • When you retire.

*Dependent Child Life insurance terminates:
  • When your Basic Life insurance terminates, or
  • When your unmarried, dependent child reaches age 20 or up to age 26 for your unmarried, dependent child who is attending school on a full-time basis.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective Date of Notice: September 23, 2013

Brethren Insurance Services (the “Plan”) is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. the Plan’s uses and disclosures of Protected Health Information (PHI);
2. your privacy rights with respect to your PHI;
3. the Plan’s duties with respect to your PHI;
4. your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
5. the person or office to contact for further information about the Plan’s privacy practices.

The term “Protected Health Information” (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, electronic).

Section 1.
Notice of PHI Uses and Disclosures

Required PHI Uses and Disclosures

Upon your request, the Plan is required to give you access to your PHI in order to inspect and copy it.

Use and disclosure of your PHI may be required by the Secretary of the Department of Health and Human Services to investigate or determine the Plan’s compliance with the privacy regulations.

Uses and disclosures to carry out treatment, payment and health care operations.

The Plan and its business associates will use PHI without your authorization to carry out treatment, payment and health care operations. The Plan and its business associates (and any health insurers providing benefits to Plan participants) may also disclose the following to the Plan’s Board of Trustees: (1) PHI for purposes related to Plan administration (payment and health care operations); (2) summary health information for purposes of health or stop loss insurance underwriting or for purposes of modifying the Plan; and (3) enrollment information (whether an individual is eligible for benefits under the Plan). The Trustees have amended the Plan to protect your PHI as required by federal law.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating physician the name of your treating radiologist so that the physician may ask for your X-rays from the treating radiologist.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims processing, subrogation, reviews for medical necessity and appropriateness of care, utilization review and preauthorizations).

For example, the Plan may tell a treating doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. However, no genetic information can be used or disclosed for underwriting purposes.

For example, the Plan may use information to project future benefit costs or audit the accuracy of its claims processing functions.

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release.

Unless you object, the Plan may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. Also, if you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, the Plan will disclose protected health information (as the Plan determines) in your best interest. After the emergency, the Plan will give you the opportunity to object to future disclosures to family and friends.

Uses and disclosures for which your consent, authorization or opportunity to object is not required.

The Plan is allowed to use and disclose your PHI without your authorization under the following circumstances:

(1) For treatment, payment and health care operations.
(2) Enrollment information can be provided to the Trustees.
(3) Summary health information can be provided to the Trustees for the purposes designated above.
(4) When required by law.
(5) When permitted for purposes of public health activities, including when necessary to report product defects and to permit product recalls. PHI may also be disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if required by law.

(6) When required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor’s parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor’s PHI.

(7) The Plan may disclose your PHI to a public health oversight agency for oversight activities required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

(8) The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request.

(9) When required for law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the Plan is unable to obtain the individual’s agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual’s agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan’s best judgment.

(10) When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

(11) When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

(12) When authorized by and to the extent necessary to comply with workers’ compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

Uses and disclosures that require your written authorization.

Other uses or disclosures of your protected health information not described above will only be made with your written authorization. For example, in general and subject to specific conditions, the Plan will not use or disclose your psychiatric notes; the Plan will not use or disclose your protected health information for marketing; and the Plan will not sell your protected health information, unless you provide a written authorization to do so. You may revoke written authorizations at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

**Section 2**

**Rights of Individuals**

**Right to Request Restrictions on Uses and Disclosures of PHI**

You may request the Plan to restrict the uses and disclosures of your PHI. However, the Plan is not required to agree to your request (except that the Plan must comply with your request to restrict a disclosure of your confidential information for payment or health care operations if you paid for the services to which the information relates in full, out of pocket).

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan’s Privacy Official.

**Right to Request Confidential Communications**

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations if necessary to prevent a disclosure that could endanger you.

You or your personal representative will be required to submit a written request to exercise this right.

Such requests should be made to the Plan’s Privacy Official.

**Right to Inspect and Copy PHI**

You have a right to inspect and obtain a copy of your PHI contained in a “designated record set,” for as long as the Plan maintains the PHI. If the information you request is in an electronic designated record set, you may request that these records be transmitted electronically to yourself or a designated individual.
"Protected Health Information" (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form.

"Designated Record Set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained off site. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to submit a written request to request access to the PHI in your designated record set. Such requests should be made to the Plan's Privacy Official.

If access is denied, you or your personal representative will be provided with a written denial, setting forth the basis for the denial, a description of how you may appeal the Plan's decision and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

The Plan may charge a reasonable, cost-based fee for copying records at your request.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in your designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

Such requests should be made to the Plan's Privacy Official.

You or your personal representative will be required to submit a written request to request amendment of the PHI in your designated record set.

Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting will not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) pursuant to your authorization; (4) prior to April 14, 2003; and (5) where otherwise permissible under the law and the Plan’s privacy practices. In addition, the Plan need not account for certain incidental disclosures.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided.

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Such requests should be made to the Plan’s Privacy Official.

Right to Receive a Paper Copy of This Notice Upon Request

You have the right to obtain a paper copy of this Notice.

Such requests should be made to the Plan’s Privacy Official.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

1. a power of attorney for health care purposes;
2. a court order of appointment of the person as the conservator or guardian of the individual; or
3. an individual who is the parent of an unemancipated minor child may generally act as the child’s personal representative (subject to state law).

The Plan retains discretion to deny access to your PHI by a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect.

Section 3
The Plan’s Duties

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of the Plan’s legal duties and privacy practices.
This Notice is effective September 23, 2013, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this Notice will be provided to all participants for whom the Plan still maintains PHI. The revised Notice will be distributed in the same manner as the initial Notice was provided or in any other permissible manner.

If the revised version of this Notice is posted on the Plan’s website, www.cobb.org, you will also receive a copy of the Notice, or information about any material change and how to receive a copy of the Notice in the Plan’s next annual mailing. Otherwise, the revised version of this Notice will be distributed within 60 days of the effective date of any material change to the Plan’s policies regarding the uses or disclosures of PHI, the individual’s privacy rights, the duties of the Plan or other privacy practices stated in this Notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. When required by law, the Plan will restrict disclosures to the limited data set, or otherwise as necessary, to the minimum necessary information to accomplish the intended purpose.

However, the minimum necessary standard will not apply in the following situations:

1. disclosures to or requests by a health care provider for treatment;
2. uses or disclosures made to the individual;
3. disclosures made to the Secretary of the U.S. Department of Health and Human Services;
4. uses or disclosures that are required by law; and
5. uses or disclosures that are required for the Plan’s compliance with legal regulations.

De-Identified Information

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual.

Summary Health Information

The Plan may disclose “summary health information” to the Trustees for obtaining insurance premium bids or modifying, amending or terminating the Plan. “Summary health information” summarizes the claims history, claims expenses or type of claims experienced by participants and excludes identifying information in accordance with HIPAA.

Notification of Breach

The Plan is required by law to maintain the privacy of participants’ PHI and to provide individuals with notice of its legal duties and privacy practices. In the event of a breach of unsecured PHI, the Plan will notify affected individuals of the breach.

Section 4
Your Right to File a Complaint With the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may complain to the Plan. Such complaints should be made to the Plan’s Privacy Official.

You may file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue SW, Washington, D.C. 20201.

The Plan will not retaliate against you for filing a complaint.

Section 5
Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Plan’s Privacy Official. Such questions should be directed to the Plan’s Privacy Official at: 1505 Dundee Ave., Elgin, IL 60120.

Conclusion

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at 45 Code of Federal Regulations Parts 160 and 164. The Plan intends to comply with these regulations. This Notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this Notice and the regulations.