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

Supplemental Life Insurance Enrollment

Employee must be enrolled in Basic Life to be eligible.

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.

SUPPLEMENTAL LIFE INSURANCE ENROLLMENT

Policyholder Name Church of the Brethren Benefit Trust Inc.____________ Employee Salary____________________________

Employer Name ____ **Effective Date** ______________

church, district, camp, agency — (The day you become eligible.)

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[1]

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[1]

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

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

Name of Employee	Social Security Number	Date of Birth	Coverage Amount
Last First MI		month/day/year	(up to 5x salary) (up to $300,000 guaranteed)

Name of Spouse	Social Security Number	Date of Birth	Coverage Amount
Last First MI		month/day/year	(up to $40,000 guaranteed[2])

A STUDENT VERIFICATION FORM IS REQUIRED FOR EACH DEPENDENT CHILD AGE 20 TO 26 — SEE NEXT PAGE.

Name of Dependent Child(ren)	Social Security Number	Date of Birth	Coverage Amount
Last First MI		month/day/year	$10,000 or $20,000 (must be same for each child)
Last First MI		month/day/year	$10,000 or $20,000 (must be same for each child)
Last First MI		month/day/year	$10,000 or $20,000 (must be same for each child)

[1]Additional form required. Contact us for details.
[2]Cannot exceed more than 50 percent of the amount chosen by the employee.

SIGNATURE

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.

______________________________________ ______________________________________

Signature of Employee *Date* *Signature of Employer* *Date*

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

CHURCH OF THE BRETHREN
INSURANCE SERVICES
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Student Verification
(Dependent child life insurance)

ACCOUNT INFORMATION

Group Name ______________________________ **Group Agreement Number** ______________________

Primary Plan Member Name: ____

Primary Plan Member Address: ____

Dependent Child Name: ____

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:** ______________