Customer Number:

r|b|a Reformed Benefits Association

2018 Group Medical Insurance Coverage Agreement

The council/consistory /board of directors of_____, a Christian Reformed Church in North America or Reformed Church in America church, institution or agency, located in _____, _____, hereby agrees to enroll all current and future full-time staff members according to the Terms of Participation in the group Medical and Basic Life insurance offered by Reformed Benefits Association. We understand other benefit offerings are optional. We have read and understand the attached Terms of Participation and agree to abide by the criteria as outlined. We have listed the names of all paid staff members in the section below (add additional names on a separate page if necessary):

STAFF INFORMATION

Please list information for all staff working at least 20 hours per week :

Name:	Participant Address	Participant City, State Zip	Full-time or Part-time	Have Coverage through Spouse	Date of Hire	Participant of RBA
				☐		☐
				☐		☐
				☐		☐

We understand we will be billed the premium based on the staff member's election, and it is our responsibility to collect any required premium from the staff members.

Authorized Signature _____ Position_____ Date _____

Printed Name:_____ Phone Number:_____

Email for RBA Communication_____

You represent and warrant that you have the authority to bind the organization named above to these Terms and you agree to be bound by these Term on behalf of such organization.

Customer Number:

REFUSAL TO PURCHASE GROUP COVERAGE (If applicable)

We hereby certify that our church, assembly or institution has **declined** to purchase any group coverage insurance benefits for our staff as offered by Reformed Benefits Association. We understand if we request to participate at a later date, we will be subject to the terms and limitations of the Reformed Benefits Association program as set forth by the Board of Trustees of Reformed Benefits Association, which could possibly include paying a penalty if we elect to participate within two years of this date.

Authorized Signature _____ Position_____ Date _____

Printed Name:_____ Phone Number:_____

Email for RBA Communication_____

You represent and warrant that you have the authority to bind the organization named above to these Terms and you agree to be bound by these Term on behalf of such organization.

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Complete, sign, and return with any certification of spousal coverage (if applicable) to:

Return by email to:
benefits@reformedbenefits.org

Reformed Benefits Association
1700 28th Street SE
Grand Rapids, MI 49508
Fax: 616-224-5896

Please return only one copy

Revised 9.17