NEW PARTICIPANT ENROLLMENT DATA REFORMED BENEFITS ASSOCIATION

PARTICIPANT INFORMATON		
Last Name:	First Name:	
Date of Birth:	SSN:	Phone:
Home Address:		
City:	State:	ZIP Code:
Gender: M ◯ F ◯	Single ◯ Married ◯ Widow ◯	Email:
Date of Hire:	Job Title:	Ordination ◯
Annual Salary: _____ Housing Allowance ◯ Parsonage ◯	Effective Date of Coverage:	Hours worked per week:
I authorize my enrollment with the Reformed Benefits Association (RBA) as of the effective date stated above. Should I experience a Qualified Change in Status, I will notify my employer within 30 days.		Church affiliation (circle one): CRC RCA ARC
Signature:		**Date:**

BILLING ENTITY INFORMATION		
Billing Entity:		
Billing Address:		Billing Phone:
City:	State:	ZIP Code:
Authorized Billing Entity Representative:		
Authorized Signature:		Date:
INTERNAL RBA USE ONLY		
Date Received:	Received by:	Database Entry:
EFT:	GCA:	
HIPAA Form:	LTD with CRC/RCA:	Additional Info:

Benefit Enrollment			
Long Term Disability (Ordained staff only):	☐		
Basic/Group Life (select one):	☐ $75,000	☐ $175,000	☐ $250,000