



## NEW PARTICIPANT ENROLLMENT DATA REFORMED BENEFITS ASSOCIATION

### PARTICIPANT INFORMATION

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 Status:    Y      N
Annual Salary:		Effective Date of Coverage:	
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.			
<b>Signature:</b> _____		<b>Date:</b> _____	

### 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: