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 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.			
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: