

**Reformed Benefits Association  
2019 Group Insurance Coverage Agreement**

The council/consistory /board of directors of \_\_\_\_\_, a church, institution or agency, located in \_\_\_\_\_, \_\_\_\_\_, hereby agrees to offering all of its staff one of the following package options:

**Check only one option**

\_\_ Option 1 Partial Coverage: enroll all current and future full-time staff members, according to the Terms of Participation, in one of the group Basic Life plans offered by Reformed Benefits Association. The employer may also offer additional voluntary benefits (excluding Medical, Dental and Vision) to eligible staff.

\_\_ Option 2: enroll all current and future full-time staff members, according to the Terms of Participation, in one of the group Medical and Basic Life insurance plans offered by Reformed Benefits Association. The employer may also offer voluntary benefits to eligible staff.

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:	Full-time or Part-time	Have Coverage through Spouse? (Y/N)	Number of hours worked per week	Date of Hire	Participant of RBA? (Y/N)

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 \_\_\_\_\_

**Customer Number:**

***\*\*\*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. 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](mailto:benefits@reformedbenefits.org)**

Reformed Benefits Association

1700 28<sup>th</sup> Street SE

Grand Rapids, MI 49508

Fax: 616-224-5896

*Please return only one copy*