



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:	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.		
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: