



EPC

Benefit Resources, Inc.

PARTICIPANT ENROLLMENT/CHANGE FORM

This is a fillable PDF form; save to your computer before completing. Incomplete or unclear information will delay enrollment. Submit completed form to your Church Administrator for processing.

Last Name	First Name	M.I.	Gender	Birthdate	SSN	Daytime Phone
Address			City	State	ZIP	
E-Mail Address						
Classification: <input type="checkbox"/> 1. EPC-Ordained Minister <input type="checkbox"/> 2. Other Ordained <input type="checkbox"/> 3. Mgmt. (Non-Ordained) <input type="checkbox"/> 4. Salaried <input type="checkbox"/> 5. Hourly Job Title:						
Reason for Enrollment:						
<input type="checkbox"/> New Hire <input type="checkbox"/> Add Dependent <input type="checkbox"/> Open Enrollment <input type="checkbox"/> Transfer from other Denomination <input type="checkbox"/> Transfer from other EPC Church (Previous church: _____) <input type="checkbox"/> Enrollment for loss of other coverage (Attach proof of loss of creditable coverage)						
Reason for Change:						
<input type="checkbox"/> Termination of Employment <input type="checkbox"/> Death <input type="checkbox"/> Address Change <input type="checkbox"/> Retirement <input type="checkbox"/> Voluntary Termination <input type="checkbox"/> Electing other coverage <input type="checkbox"/> Transfer to another church (Name/Billing ID of new church: _____)						

List all dependents to be covered by this enrollment

Provide a second form for additional dependents.
 (For new dependents, BRI must be notified within 30 days of Qualified Life Event)

	First Name	M.I.	Last Name (if different from Participant)	SSN	Sex	Birthdate
Spouse					<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent					<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent					<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent					<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent					<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent					<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent					<input type="checkbox"/> M <input type="checkbox"/> F	
Dependent					<input type="checkbox"/> M <input type="checkbox"/> F	



EPC

Benefit Resources, Inc.

PARTICIPANT ENROLLMENT/CHANGE FORM

Employee Name _____

Medical/Prescription Drug Plan					<input type="checkbox"/> I decline Medical/Prescription Drug Plan coverage
<input type="checkbox"/> Platinum	<input type="checkbox"/> Single	<input type="checkbox"/> Couple	<input type="checkbox"/> Family	<input type="checkbox"/> EE & Children	
<input type="checkbox"/> Gold	<input type="checkbox"/> Single	<input type="checkbox"/> Couple	<input type="checkbox"/> Family	<input type="checkbox"/> EE & Children	
<input type="checkbox"/> Gold HDHP	<input type="checkbox"/> Single	<input type="checkbox"/> Couple	<input type="checkbox"/> Family	<input type="checkbox"/> EE & Children	
<input type="checkbox"/> Silver	<input type="checkbox"/> Single	<input type="checkbox"/> Couple	<input type="checkbox"/> Family	<input type="checkbox"/> EE & Children	
<input type="checkbox"/> Bronze HDHP	<input type="checkbox"/> Single	<input type="checkbox"/> Couple	<input type="checkbox"/> Family	<input type="checkbox"/> EE & Children	

Dental Plan					<input type="checkbox"/> I decline Dental Plan coverage
<input type="checkbox"/> Low Plan	<input type="checkbox"/> Single	<input type="checkbox"/> Couple	<input type="checkbox"/> Family	<input type="checkbox"/> EE & Children	
<input type="checkbox"/> High Plan	<input type="checkbox"/> Single	<input type="checkbox"/> Couple	<input type="checkbox"/> Family	<input type="checkbox"/> EE & Children	

Vision Plan					<input type="checkbox"/> I decline Vision Plan coverage
<input type="checkbox"/> Vision	<input type="checkbox"/> Single	<input type="checkbox"/> Couple	<input type="checkbox"/> Family	<input type="checkbox"/> EE & Children	

Employer-Paid Life/Long-Term Disability (Bundled)	
<input type="checkbox"/> Elect	<input type="checkbox"/> Decline

Supplemental Life/Accidental Death & Dismemberment (AD&D)					
<input type="checkbox"/> Elect <input type="checkbox"/> Decline					
Employee Benefit:	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$30,000	<input type="checkbox"/> \$40,000	<input type="checkbox"/> \$
Spouse Benefit:	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$
Child(ren) Benefit:	<input type="checkbox"/> \$10,000 per child				

Employee Signature _____ Date _____

To be Completed by Church Officer (Required for BRI to Process This Form)		
Date of Employee Hire	Effective Date of Enrollment/Change	Employee Annual Salary
Church Customer Number from Invoice (Existing EPC Churches only):		
Church Name (Employer)		
Church City/State:	Church Phone:	
Church Officer Name:	Officer Email:	

Church Officer Signature _____ Date _____