



**EPC**

*Benefit Resources, Inc.*

**BILLING SETUP FORM**

To get set up through EPC Billing Administration, please complete and return this form to *benefits@epc.org* or fax to 407-930-4492. This form is for invoicing purposes only.

Church/Organization Name \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Church/Organization City and State \_\_\_\_\_

Billing Contact Person \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Billing Contact Email Address \_\_\_\_\_

Billing Address \_\_\_\_\_

Street Address

City/State/ZIP (required)

Choose one of the following for enrollment status:

- New EPC Church (Date Received into the EPC: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_)
- Existing EPC Church enrolling in coverage for the first time.
- Pastor Out of Bounds\* —*Eligible for Medical, Dental, and Vision (Not Life or LTD)*
- Retiree Coverage\* —*Eligible for Medical, Dental, and Vision (Not Life or LTD)*
- Pastor Without Call\* —*Eligible for Medical, Dental, and Vision (Not Life or LTD)*

\*EPC presbytery approved ministries only

Effective Date of Coverage \_\_\_\_\_

Signature of Authorized Church Representative \_\_\_\_\_ Date \_\_\_\_\_

.....**Presbytery Use Only**.....

Presbytery \_\_\_\_\_

I acknowledge that \_\_\_\_\_ (individual/church) is in good standing with the EPC to enroll/continue coverage in the EPC Benefit Plan under the status noted.

Signature of Authorized Representative \_\_\_\_\_ Date \_\_\_\_\_

.....**Benefit Resources, Inc., Use Only**.....

Signature of Authorized Representative \_\_\_\_\_

Date \_\_\_\_\_ Customer ID \_\_\_\_\_