Group Life and Disability Enrollment Form

Reformed Church in America
Board of Benefits Services
475 Riverside Drive, Suite 1606
New York, NY 10115
retirement@rca.org
Fax: 833-627-7620

RCA Board of Benefits Services

1. **Participant Information**

Last Name: _____ First Name: _____ MI: ____ Gender: ☐ Male ☐ Female

Social Security Number: _____ Date of Birth: _____/_____/_____ Marital Status: ☐ Single ☐ Married

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Ordination Status: ☐ Minister of word and Sacrament ☐ Supplemental D Pastor ☐ Commissioned Pastor

2. **Employer Information**

Employer Name: _____ Work Start Date: _____

City: _____ State: _____ Number of hours worked per week: _____

Billing Contact Name: _____

Phone Number: _____ Email: _____

3. **Salary Information – ALL PARTICIPANTS MUST COMPLETE**

Total annual cash salary: $ _____ (salary + housing allowance designation)

Amount of annual cash salary designated as housing allowance: $ _____

Parsonage: ☐ Yes ☐ No

Effective Date of Salary: _____

4. **LTD Insurance – BCO Requirement**

☐ Enroll in Long Term Disability Insurance provided by RCA BOBS

☐ Decline Long Term Disability Insurance (I am not mandated by the BCO)

**Salary information is used to determine LTD Premium and amount of insured salary.*

5. **Group Life Insurance/Accidental Death & Dismemberment – BCO Requirement**

☐ Enroll in Group Life Insurance provided by RCA BOBS

☐ Decline Group Life Insurance (My life insurance is provided by RBA or I am not mandated by the BCO)

<u>Voluntary Life Insurance</u> – Optional/No BCO Requirement

6. **Employee Life Insurance/Accidental Death & Dismemberment (for participant)**

☐ Enroll in Voluntary Life

Coverage Amount: _____, increments of $10,000 up to a maximum of $500,000

- May only enroll within 31 days of when you are first eligible
- Maximum coverage amount cannot be greater than 5x annual salary
- Amounts over $200,000 require Proof of Good Health and will not be effective until approved by the insurer
- If you are a late enrollee, you may only elect voluntary life during an annual enrollment period

☐ Decline Voluntary Life

7. **Spouse Life Insurance/Accidental Death & Dismemberment – enrollment in Employee Life is required**

☐ Enroll in Voluntary Spouse Life

Coverage Amount: _____, increments of $5,000 up to a maximum of $250,000

- May only enroll within 31 days of when you are first eligible
- Amounts over $30,000 require Proof of Good Health and will not be effective until approved by the insurer
- Spouse Life coverage amount may not exceed 100% of Voluntary Life coverage amount
- If you are a late enrollee, you may only elect spouse life during an annual enrollment period

Spouse Name: _____ Gender: ☐ Male ☐ Female

Social Security Number: _____ Date of Birth: _____/_____/_____

☐ Decline Voluntary Life

8. **Child Life Insurance – enrollment in Employee Life is required**

☐ Enroll in Voluntary Child Life

Coverage Amount: _____, increments of $2,000 up to a maximum of $10,000

- May only enroll within 31 days of when you are first eligible
- Coverage applies to all eligible, unmarried children under age 26
- If you are a late enrollee, you may only elect child life during an annual enrollment period

☐ Decline Voluntary Child Life

9. **Sign and Return**

I declare that the information given in this enrollment form is true and complete to the best of my knowledge and belief. I understand that this information will be used by the insurer (where applicable) to determine me and my dependents' insurability. I further understand that if I do not elect coverage when I (or my dependent) am first eligible, evidence of good health satisfactory to the insurer will be required. Coverage will not take effect, or it will be limited to any guaranteed issue amount, until the insurer has approved the coverage or increase request. I understand that if I am not actively at work on my coverage effective date, coverage will not go into effect until I have been actively at work for one full day. I understand that on the date dependent insurance is scheduled to take effect, my dependent must not be hospitalized or confined at home under a physician's care. If my dependent does not meet this requirement, coverage will take effect on the date my dependent is no longer confined.

By my signature below, I acknowledge that I have read and understand the statements and declarations made in this enrollment form.

Printed Name: _____ Date: _____

Signature: _____

Please return the completed form to the Life and LTD Administrator, Cineca Anthony, by mailing, e-mailing, or faxing using the contact info above.