



Legal Name: The Evangelical Benefit Trust
Version: EBT / Enrollment / 0909

Submit to:
Benefit Services
PO Box 950
Forest Hill, MD 21050

p 866.902.6227
f 866.903.6227

Adobe Reader Version 7 or later is required to complete this form. Download the FREE update at www.adobe.com

ENROLLMENT/MEDICAL INFORMATION

Please complete this fillable form and click the Submit button. Then save it, print it, sign it and fax it to the number shown above.

Begin by selecting ONE of the following boxes:

New Enrollee

COBRA Enrollee

COBRA Qualifying Event Date: _____(mm/dd/yyyy)

COBRA Qualifying Event: _____

SECTION I. EMPLOYER INFORMATION

Employer Name: _____ Location (if more than one): _____

SECTION II. EMPLOYEE INFORMATION

Employee Social Security No. _____

Last Name:		First Name:		MI:	
Address:		City:	State:	Zip Code:	
Home Phone:	Single	Married	Male	Female	Height:
Date Of Birth: _____ <small>(mm/dd/yyyy)</small>		E-mail: _____			
Date Employed Full Time: _____ <small>(mm/dd/yyyy)</small>		Hours Worked Per Week:		Occupation:	

NOTE: Requested Effective Date of Coverage subject to employer waiting period and other limitations that may apply.

SECTION III. COVERAGE SELECTION (Subject to the plan options selected by your employer)

Select ONE of the following: Employee Only EE + Spouse EE + Child(ren) EE + Family

SECTION IV. FAMILY INFORMATION (please complete for all persons to be covered)

First Name & M.I. (last name if different)	Gender		DOB MM/DD/YYYY	F/T Student*		Height	Weight	Social Security No. No Hyphens
	M	F		Yes	No			
Spouse:								
Child:								
Child:								
Child:								
Child:								
Child:								
Child:								
Child:								
Child:								

* Full time students ages 19 - 24 must carry 12 credits per semester. Student certification required from accredited college.

SECTION VII. EMPLOYEE AGREEMENT/AUTHORIZATION TO RELEASE MEDICAL INFORMATION - Signature Required

I UNDERSTAND that the above answers shall be the basis for the Plan to issue a Summary Plan Description. **I DECLARE** all statements contained in this entire form are true and correct and that no material information has been withheld or omitted. I understand and agree that the Plan Administrator is not bound by any statement made by or to any agent unless written herein. **I UNDERSTAND AND AGREE** that no coverage will be effective until the date specified by the Plan Administrator.

I HEREBY apply for participation in the Plan for my dependents and myself listed above. To assist the Plan Administrator with determining my creditable coverage, I authorize any insurance company, third party administrator or other authorized carrier, to release to the Plan Administrator certificates of creditable coverage and all such information. **I HEREBY AUTHORIZE** any physician, medical practitioner, hospital, clinic, Veterans administrations facility, other medical or medically related facility, insurance or reinsurance company, or Consumer Reporting Agency, having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition, including drug or alcohol abuse, and/or treatment of me or my minor children and other non-medical information of me and my minor children, to release to the Plan Administrator, any and all such information.

I UNDERSTAND that I may request a copy of this authorization at any time. I agree that a photographic copy of this authorization shall be as valid as the original, and that this authorization shall be valid for 2 1/2 years from the date shown below. I understand the information obtained by use of this authorization may be used by the Plan Administrator for health benefit underwriting. Any information obtained will not be released to any person or organization, except to reinsuring companies or other persons or organizations performing business or legal services in connection with my enrollment for the coverage, for any claim, for medical management purposes, or as may be otherwise lawfully required or as I may further authorize.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraudulent act against an insurer, submits an Enrollment, Participation, or other required form or files a claim containing a false or deceptive statement, material misrepresentation or material omission commits a fraudulent insurance act, which is a crime, and subjects the person to civil and criminal penalties.

BY SIGNING BELOW, I UNDERSTAND AND AGREE that all of the above questions must be answered completely and truthfully and that any additional information must be provided and that failure to answer these questions completely and truthfully may result in loss of coverage for any or all those persons included on this application.

Applicant Signature: _____ Date: _____(mm/dd/yyyy)

Spouse Signature: _____ Date: _____(mm/dd/yyyy)