

SUPPLEMENTAL LIFE INSURANCE ENROLLMENT

CHURCH OF THE BRETHREN MEDICAL PLAN

Return form to the Church of the Brethren Medical Plan office

Aetna U.S. HealthCare Group Insurance Enrollment

Policyholder Name Church of the Brethren Benefit Trust	Employer Name (church, district, camp)	Control Number: 697943-20-120
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OPTIONAL LIFE INSURANCE

Name of Employee			Social Security No.	Date of Birth		
Last	First	M.I.		Mo.	Day	Year
Name of Beneficiary			Relationship	Date of Birth		
Last	First	M.I.		Mo.	Day	Year
Address of Beneficiary						

I make the nomination of beneficiary with respect to optional life insurance only provided now or at any time in the future under such policy or policies hereby revoking prior nominations for such insurance, if any, and reserve to myself the privilege of making other and further changes subject to the policy provisions. If more than one beneficiary is designated, settlement will be made in equal shares to such of the designated beneficiaries (or beneficiary) as survive me, unless otherwise written on my beneficiary form. If no designated beneficiary survives me, settlement will be made as provided in the policy(ies.)

I hereby apply for optional life insurance to which I am entitled or to which I may become entitled under the provisions of the group policy or policies issued by Aetna U.S. HealthCare and authorize deductions from my earnings of the required contribution, if any, toward the cost of the insurance.

I understand that if I apply for optional life insurance after 31 days from the date of eligibility, I will have to furnish at my own expense evidence of my insurability satisfactory to the insurance company before insurance can become effective.

I UNDERSTAND THAT FUTURE CHANGES IN MY INSURANCE, BECAUSE OF SALARY INCREASES, WILL HAVE TO BE REQUESTED BY ME, IN WRITING, TO MY EMPLOYER.

Date _____ Signature _____

INITIAL AMOUNT OF INSURANCE

Effective date	Insurance dollar amount

CHURCH OF THE BRETHREN MEDICAL PLAN
a ministry of Church of the Brethren Benefit Trust, Inc.
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