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: ☐ Salaried ☐ Hourly

☐ 1. EPC-Ordained Minister ☐ 2. Other Ordained ☐ 3. Mgmt. (Non-Ordained)

☐ 4. Pastor Out of Bounds ☐ 5. Pastor without a call

Job Title:

Reason for Enrollment:

☐ New Hire ☐ Add Dependent (Life Event) ☐ Open Enrollment (OE) ☐ Transfer from other Denomination.
☐ Employment status changed from part-time to full-time.
☐ Transfer from other EPC Church (Previous church: ____________________)
☐ Enrollment for loss of other coverage (*Attach proof of loss of creditable coverage*)

Reason for Change:

☐ Termination of Employment ☐ Death ☐ Address Change ☐ Retirement ☐ Medicare Eligibility
☐ Voluntary Term (Life Event/OE Only) ☐ Electing other coverage ☐ Pastor w/out Call/Out of Bounds
☐ Transfer to another church (Name/Billing ID of new church: ____________________)

Presbytery Transition:

☐ Transfer to another church ☐ Transfer to Pastor Out of Bounds

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)

	ADD/ DROP	First Name	M.I.	Last Name (if different from Participant)	SSN	Sex	Birthdate
Spouse						☐ M ☐ F	
Dependent						☐ M ☐ F	
Dependent						☐ M ☐ F	
Dependent						☐ M ☐ F	
Dependent						☐ M ☐ F	
Dependent						☐ M ☐ F	
Dependent						☐ M ☐ F	
Dependent						☐ M ☐ F	

EPC
Benefit Resources, Inc.

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Employee Name ______________________________

Medical/Prescription Drug Plan	☐ I decline Medical/Prescription Drug Plan coverage			
☐ Platinum POS	☐ Single	☐ Couple	☐ Family	☐ EE & Children
☐ Gold POS	☐ Single	☐ Couple	☐ Family	☐ EE & Children
☐ Gold HDHP	☐ Single	☐ Couple	☐ Family	☐ EE & Children
☐ Silver POS	☐ Single	☐ Couple	☐ Family	☐ EE & Children
☐ Bronze HDHP	☐ Single	☐ Couple	☐ Family	☐ EE & Children

Dental Plan	☐ I decline Dental Plan coverage			
☐ Low Plan	☐ Single	☐ Couple	☐ Family	☐ EE & Children
☐ High Plan	☐ Single	☐ Couple	☐ Family	☐ EE & Children

Vision Plan	☐ I decline Vision Plan coverage			
☐ Vision	☐ Single	☐ Couple	☐ Family	☐ EE & Children

Employer-Paid Life/Long-Term Disability (Bundled) *(Active Employees Only)*
☐ Elect ☐ Decline

Employee Signature ____ **Date**__________________

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

Church/Presbytery Officer Signature ______________________________ **Date**__________________

Pastor Out of Bounds/Pastor Without Call (To be completed and signed by the presbytery)

To be Completed by Presbytery Officer (Required for BRI to Process This Form)	
Effective Date of Enrollment/Change:	
Billing Information Update:	
Employee Name:	
Billing Address:	Phone:
City/State/ZIP:	Email:

Presbytery Officer Signature ____ **Date**__________________