

# APPLICATION FOR COVERAGE

Christian Church Health Care Benefit Trust

INDIVIDUAL

**Please complete application in blue or black ink. Do not write in shaded areas; these are for internal use only.**

Check any that apply <input type="checkbox"/> I am applying for NEW coverage <input type="checkbox"/> I am applying to upgrade/downgrade coverage <input type="checkbox"/> I am applying to add dependent(s) to my current coverage	Requested effective date, month
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**Section A Applicant Information**

Risk Tier	Last name of applicant	First name	MI	Social Security number
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Home address: Street and P.O. Box if applicable	City, State, ZIP Code
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County	Height	Weight	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date of birth
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Billing address: Street (if different than above)	City, State, ZIP Code
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Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	Home Phone (include Area Code)	Business Phone (include area code)	Occupation
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Are all persons applying for coverage legal residents of the U.S.?  Yes  No

**Section B Select Type of Coverage and Plan/Deductible Desired**

<input type="checkbox"/> Single	<input type="checkbox"/> Employee + One	<input type="checkbox"/> Family	<input type="checkbox"/> Employee +Children
<input type="checkbox"/> Health Choice 500	<input type="checkbox"/> Health Choice 1000	<input type="checkbox"/> HSA Choice 2500	

**Section C Billing Information**

Select premium frequency: <input type="checkbox"/> monthly <input type="checkbox"/> quarterly <input type="checkbox"/> semi-annually <input type="checkbox"/> annually	Total Premium Payment Amount Enclosed  \$ _____ Make your check for the first premium period payable to "Christian Church Health Care Benefit Trust."
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**Section D Dependent Information (Attach a separate sheet if necessary)**

Dependent information must be completed for all dependents (if any) to be covered under this coverage. Eligible dependents may be your spouse, your unmarried dependents, your spouse's unmarried dependents (to the end of the calendar month in which they turn 19, or to age 25 if the child qualifies as a full-time student or qualifies for federal income tax exemption.)

Risk Tier	First, MI (Last name if different from applicant)	Social Security #	Sex	Age	Date of Birth	Relationship To Applicant	Height	Weight	Federal Tax Exemption?

Does any dependent listed above, who is over age 19, current qualify for federal income tax exemption or as a full-time student? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, provide dependent's name and address, if different than the applicant's address. (Documentation of qualification for federal income tax exemption or as a full-time student may be required.)
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Assigned Effective Date	Decision Date	Pre-existing Provision	UW initials	Risk Code
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**Risk Tier Key**

(P) Preferred   (S1) Standard 1   (S2) Standard 2   (M1) Modified 1   (M2) Modified 2



