

# Employer Enrollment Form for Covenant Mutual Benefits Plan (COMB)

For Congregations, Conference Offices, and Denominational Offices



1. Congregation or office \_\_\_\_\_ Telephone number \_\_\_\_\_

Address \_\_\_\_\_  
Street City State ZIP code

2. List all conferences you are affiliated with \_\_\_\_\_

3. Contact person \_\_\_\_\_ Birth date \_\_\_\_\_

Address (if different from the congregation's) \_\_\_\_\_

City State ZIP code Telephone number \_\_\_\_\_

## To waive health coverage or decline participation

4. I understand that my congregation has been given a limited-time offer to enroll our church's employees in COMB without underwriting.

- We waive participation in COMB because we do not have any eligible employees at this time.** We understand that by choosing this option, any eligible employees we have in the future can participate in COMB as long as we enroll them within the eligibility period. We agree to pay \$50 annually to our conference.
- We decline to participate in COMB.** We understand that by declining participation, any employees we wish to enroll later will be underwritten and all of the congregation's employees may be declined enrollment.
- We waive participation in health only (CEP) because all eligible employees are currently enrolled in other health coverage.** We have attached a health plan waiver signed by each of these employees, but we understand they will be enrolled in life, accidental death and dismemberment, and long-term disability insurance. In addition, we recognize they will be enrolled in dental and vision coverage (if we select them as benefits) unless they have other coverage and therefore can choose to waive these coverages. And, they may participate in the Section 125 FlexChoice plan to help cover their medical, premium, or dependent care expenses. We are submitting applications for life and accidental death and dismemberment insurance, long-term disability insurance, and all other relevant applications or waivers.

*If you have checked the first or second box under Question 4, skip to the end of this form and sign and date it. If you selected the third box, go to the next question, but you may skip Question #8.*

## To enroll in Covenant Mutual Benefits Plan

When you enroll your employees in COMB, your eligible employees receive life, accidental death and dismemberment, and long-term disability insurance. If you choose vision or dental coverage (or both), your employees will also receive those coverages – unless they waive coverage because they already have this coverage.

5. How many pastors and other permanent employees does your congregation have who work at least 20 hours a week? \_\_\_\_\_

Are they all covered by worker's compensation?  yes  no

6. Is your congregation in a church planting situation?  yes  no

7. If you want the bill sent to someone other than the contact person:

Name \_\_\_\_\_

Address \_\_\_\_\_

City State ZIP code

8. Congregational Employee Plan health benefit packages offered by your denomination:

**Single (self-only) coverage**

Deductible            \$3,000                  \$4,000      

**Family coverage**

Deductible            \$6,000                  \$8,000      

*After deductible, the plan pays 100% of eligible expenses.*

Which one of the above health benefit packages is your congregation offering its employees?

\$3,000/\$6,000 deductible       \$4,000/\$8,000 deductible

9. Optional benefits. Check all you want to provide your employees.

Vision\*

Dental\*

*\*If you select this benefit, all your employees and their families who enroll in COMB will get this benefit – unless they waive due to other dental or vision coverage.*

10. When do you want all coverages to be effective for your employees? \_\_\_\_\_

11. What percentage of the premiums is the congregation contributing?

Please note that the congregation must contribute a minimum of 100 percent of the employee premium (when only the employee is covered) **or** 50 percent of the total family premium (when the employee's family is also covered).

**Employee only**

**Family**

a. Health premiums:      \_\_\_\_\_      \_\_\_\_\_

b. Vision premiums:      \_\_\_\_\_      \_\_\_\_\_

c. Dental premiums:      \_\_\_\_\_      \_\_\_\_\_

As the contact person between MMA and the employees of my congregation (conference or district office, or denominational office), I understand:

- A. All benefits: Premiums must be paid when due (allowing for a 30-day grace period) to ensure that the employees' coverage is continuous. Failing to do this will result in coverage being canceled.
- B. New employees and dependents must enroll in COMB within 90 days of when they become eligible for coverage. This ensures that they will receive the full benefits of belonging to a group plan. Failing to add employees and their families within eligibility guidelines will result in MMA assessing their current health conditions. Employees and their families may be denied coverage.
- C. Enrollment in COMB is dependent on my conference and my congregation meeting participation requirements.

I, the contact person, have read and understand my responsibilities as outlined above.

\_\_\_\_\_  
Signature of contact person

\_\_\_\_\_  
Date