



Transfer of Benefits

****Please note that a Termination of Employment form from your previous employer is also required in order to process a transfer of benefits****

This letter is to request the transfer of insurance for the following employee to the following Covenant organization.

Name Social Security Number

Effective date of change

Updated home address

Phone Home email

Type of health coverage: (Note: If your health insurance coverage is changing at the time of transfer, please request the appropriate form to complete the change)

- Individual coverage
- Family Coverage
- Waive health insurance and elect only life & long-term disability insurances

Employment Information

Employer name

Billing address

Phone Work email

Check one: Minister Church Worker Missionary

Check one: Full time (30 or more hours per week) Part time (20-29 hours per week)

Annual base salary (include SECA paid to minister or withheld from check)

Parsonage provided? (do not include in base salary) Yes No

Housing allowance (do not include in base salary)

Signature

Treasurer/Business Manager Signature

Return completed form to Bethany Benefit Service

Mail: P.O. Box 316560; Chicago, IL 60631-6560

Fax: (773) 784-2249

Email: bethany@covchurch.org