




Anglican Benefits Program

2009 Enrollment Form

Employee Name: (Last, First, Middle Initial)		Social Security Number:	
Address: (Mailing)		Date of Birth:	Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/>
City:	State and Zip Code:	Date of Hire:	Gender Male <input type="checkbox"/> Female <input type="checkbox"/>
Annual Salary:		Home Telephone Number:	

Vision:  Employee Only EE & Spouse EE & Child(ren) EE & Family Decline Vision

Short Term Disability Plan:  Elect Decline Short Term Disability Clergy Lay Person

Long Term Disability Plan:  Elect Decline Long Term Disability Clergy Lay Person

* Life Benefit:  Designated Life Beneficiary: _____ Relationship: _____

*** \$50,000 of Life and Accidental Death & Dismemberment for Employee Only Included**

Dependent Name	Date of Birth	Social Security #	Relationship	Gender
			Spouse / Child (Circle One)	
			Child	
			Child	
			Child	
			Child	
			Child	

Employee Signature _____ Date _____

Parish Authorization _____ Date _____

Parish:	Parish Contact:	Diocese / Convocation:
Address (Mailing)		Parish Telephone Number
City	State and Zip Code	Parish Email Address