compbenefits
VISION
DENTAL

Benefits Enrollment Form

Group Name: Ohio Ministries of the Church of God

Please complete the following information:					
Social Security No.	Last Name		First	Middle	Date of Birth
Home Address			Home Phone		Gender
City	State	ZIP Code	Dental Facility # (DHMO Only)		

List All Your Eligible Dependents That Are To Be Covered			
First MI Last	Dental Facility # (DHMO Only)	Sex	Birth Date
Spouse:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /
Child:		M ☐ F ☐	/ /

Effective Date:	Your E-mail Address	Agent Number
		087009OH

PLEASE CHECK YOUR CHOICE	☐ Dental – EC405 (8UAP03-16)	☐ Vision Plan (VOH90-1)	☐ Dental – C550 (C550-79)
	Monthly	Monthly	Monthly
Member Only	☐ $26.00	☐ $ 6.94	☐ $12.58
Member + Spouse	☐ $52.74	☐ $13.86	☐ $21.48
Member + Child	N/A	N/A	☐ $29.12
Member + Children	☐ $50.04	☐ $13.18	☐ $36.60
Member + Family	☐ $83.28	☐ $20.70	☐ $43.54

I wish to enroll in the Plan. I understand that this is a MINIMUM ONE (1) YEAR CONTRACT and that all necessary services will be provided as described in the schedule of benefits which I have received and understand.

Date: _____

Applicant's Signature: X _____

Agent Signature: _____

Enrollment Instructions:

1. Complete the attached application. (Be sure to list on the previous page all family members to be included.)
2. Select your payment type:
   - If MONTHLY, complete the appropriate Authorization for Deduction **(If selecting Bank Draft, please enclose the first month's payment and a blank, voided check)**.
   - If ANNUAL, complete the Bank Card Authorization for Deduction or enclose a check for the full annual amount (Monthly premium times 12).

Make check payable to CompBenefits.
Send all information and check (if applicable) to:

CompBenefits Corporation
100 Mansell Court E, Ste 400
Roswell GA 30076

Bank Draft Authorization for Deduction—Signature Required

Name _____ Social Security # _____
Last First M.I

I authorize _____
Financial Institution

To make a Monthly Bank Draft (drafted on the 15th)

Deductions of $ _____
Contribution

❑ My checking account # _____ (Monthly Only)

Routing # _____

and to remit the amounts deducted to **CompBenefits (CB)** upon instructions from **CB**. The amount of deduction indicated above is approximate and may be corrected as instructed by **CB**. This authorization shall cease (a) upon my giving written cancellation to you; (b) automatically upon my termination as an employee, member or depositor, as the case may be, of the above-named organization; (c) automatically upon termination of my checking, savings or share account number above as this authorization relates to such an account; or (d) upon discontinuance of the deduction and remittance arrangements between the above-named organization and **CB**. I understand this authorization does not waive or change any of the payment provisions of any policy issued to me by **CB** and if this authorization terminates for any reason, any further payments required under said policy(ies) shall be made as provided in the policies. I agree that the above-named organization is acting gratuitously and for my sole accommodation and not as an agent for **CB**.

Date _____ Signature X _____

Bank Card Selection
For Your Convenience

Fill in card number

❑ MasterCard ❑ Visa ❑ Discover ❑ AMEX
Check One

Expiration Date
Mo. Yr.

Bank Card Authorization for Deduction (Signature Required)

❑ Monthly deduction of $_____

❑ Annual payment of $ _____

I hereby authorize charging my bank card.

Cardholder's Signature Date_____

X_____

PRINT NAME: _____

TO: THE FINANCIAL OR OTHER ORGANIZATION NAMED ON THE REVERSE SIDE.
In consideration of your paying checks and drafts drawn or purported to be drawn by the undersigned on the checking account of any of your depositors, undersigned hereby agrees that:

(1) It will indemnify you against and hold you harmless from any and all liability, loss, damage and expense which may be incurred by your because of your payment or dishonor of any such checks so drawn or purported to be drawn whether the payment or dishonor was intentional or through inadvertence, and will further indemnify and hold you harmless from any liability to any persons making claims under any Agreement with respect to which checks are drawn. We will refund you any amount erroneously paid by you on any such check;

(2) It will refund to you any amount erroneously paid by your to undersigned on any such check if claim is made therefore by you within 3 months from the date of payment; and

(3) Either you or undersigned may terminate this agreement by ten (10) days prior written notice by either to the other or the agreement will be immediately terminated on the closing of the depositor's account or by the revocation by the depositor of authorization, but any such termination shall not affect undersigned's obligations and liabilities hereunder with respect to any such checks or dishonored by your prior to termination.

CompBenefits Corporation

Secretary _____