

Benefit Plan Enrollment Form

United American Insurance Company
Plan Sponsor: INDIANA CONFERENCE UNITED METHODIST CHURCH

Please print clearly in ink or type

Retiree/Surviving Spouse's Name: _____
First Middle Last

Street: _____

City, State, Zip: _____ Social Security #: _____

Sex: _____ Date of Birth: _____ Medicare ID #: _____
(on Medicare Card)

Phone Number: _____ E-Mail Address _____

Spouse's Name (Only if enrolling): _____
First Middle Last

Sex: _____ Date of Birth: _____ Social Security #: _____
Medicare ID #: _____
(on Medicare Card)

I wish to enroll in the Indiana Conference Retiree Medical Benefit Program

Check Desired Coverage:

	Plan A Medical & Rx	Plan B Medical & Rx
Retiree Only	<input type="checkbox"/>	<input type="checkbox"/>
Retiree & Spouse	<input type="checkbox"/>	<input type="checkbox"/>
Surviving Spouse	<input type="checkbox"/>	<input type="checkbox"/>

Please be sure to date and sign this form, answering all questions.
 Return the form to: **NEBCO/Indiana Conference, 16 International Way, Warwick, RI 02886**

Date: _____ Retiree Signature: _____
 Date: _____ Spouse Signature: _____ (if enrolling)
 Date: _____ Surviving Spouse Signature: _____ (if enrolling)