Eder Financial

BOLD. BALANCED. TRUSTED.

1505 Dundee Avenue • Elgin, Illinois 60120-1619
800-746-1505 • 847-695-0200 • Fax 847-742-6336
insurance@eder.org • www.ederfinancial.org

Please complete and return to insurance@eder.org for preliminary registration

Once Eder Health and Life Benefits enters the basic employee information, it is the employee's responsibility to register online at https://ederfinancial.mybenefitchoice.com within 31 DAYS OF YOUR HIRE DATE (first date of payroll).

Employee First Name: ____________________ Last Name: ______________ MI: __________

Employee Address: ____

City: ____________________ State: __________ ZIP: _________ Phone: ______________

Birth Date: _______________ Social Security Number: _______________ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married Email: ______________________________

TO BE COMPLETED BY EMPLOYER **If you are a retiree, the employeer section is not needed.**

Employer Address: ____

Employer or Congregation Name: ______________________________________

City: ____________________ State: __________ ZIP: _______________

Church Code

Contact Person: _________________________ Phone: _______________

Email: _______________________ ☐ Invoices are sent electronically to contact person listed.

Name of District: _________________

For office use only
Participant ID Number: ______________

EMPLOYEE INFORMATION

Job Title: __________________________ Hours Worked/Week: ______________________

Expected Annual Earnings: _______________ ☐ Salary ☐ Hourly

Date of hire (first date on payroll): _______________ **This is your effective date of coverage. Registration must be completed within 31 days of this date.**

_____ Milliman requires automatic payment out of the Church/Employer bank account. You must return the EFT Authorization Form to Insurance@eder.org so that preliminary registration can be completed.

_____If you are enrolling in disability coverage, please complete the appropriate budget worksheet.

I understand that misstatements, misrepresentations, or omissions may result in my insurance coverage being void as of its effective date with no benefits payable. I hereby request the group insurance coverage for which I am or may become eligible and authorize deductions from my earnings to serve as payment for any required contributions. Fraud Warning Notice: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits a request for enrollment or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Minimum required = 16 hours per week. May vary by Employer Group