



# 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 employer section is not needed.

Employer Address: \_\_\_\_\_

Employer or Congregation Name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Church Code

Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_  Invoices are sent electronically to your contact person listed.

Name of Denominational District/Region (if applicable): \_\_\_\_\_

**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.