



Dear Church Family,

Life and Disability insurance is offered to all AMIA affiliated churches. This coverage is available to full-time clergy as well as lay employees and is strictly optional. However, any church who wishes to waive coverage must have all full-time employees complete section F of the enrollment form and forward to this office. Additionally, any employee who works at a church that currently is enrolled in the insurance program but does not want to participate must complete and return to this office section F of the enrollment form.

It is the responsibility of each church to let AMIA know when there is a change to employee status. This not only is in reference to terminations but also changes in wage, marital status, beneficiary status etc.

Enclosed are forms which cover all issues that may arise. Please complete the correct form and forward to this office, whenever changes occur.

Enrollment Form: This form should be used for each new hire. Sections A-D should be completed by the employee, signed, dated and forwarded to this office. **Note: It is very important that the full name of the church is clearly written under the Employers Name (Section A).**

Census Form: This form should be used for any employee change in address, marital status, beneficiary status, etc. **It is extremely important to complete this form when yearly raises occur as insurance rates are based on job classification and earnings.**

Estimated Worksheet: This form should be used to calculate projected cost per employee for insurance premiums due per quarter. This form should be completed quarterly. One copy should be kept on file at the church and one copy forwarded to AMIA.

Termination Form: This form should be completed **as soon as** an employee has been terminated. If the employee is relocating to another church that information should also be filled out. *(Make sure to include the full name of the church on all forms submitted).*

Please Note: All invoices are submitted to the churches on a quarterly basis. Each church that participates will receive four invoices per year; in February, May, August, and November. Each invoice is generated and mailed 45 days in advance of quarter billed.

If you have not previously done so, please complete and return copies of the enclosed documents to the Finance Department at AMIA.

Do not hesitate to contact this department with any questions regarding billing or the coverage itself.

Peace and Blessings,

Peggy Hibbs

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Bookkeeper
Anglican Mission in the Americas
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Brief Synopsis of Life, AD&D and Long-Term Disability Insurance Coverage

For **Life and AD&D** coverage, employees are broken down into two classes. Class 1 employees are all full-time clergy and Class 2 employees are all other full-time employees (including full-time Lay employees). Full-time employees are those who regularly work a minimum of 30 hours/week.

For Class 1 employees, the amount of insurance provided is \$50,000 Life and \$50,000 AD&D. For Class 2 employees, the amount of insurance provided is \$25,000 Life and \$25,000 AD&D. In all cases, the Life and AD&D Insurance will be reduced as follows:

- At age 65, benefits will reduce by 35% of the original amount;
- At age 70, benefits will reduce an additional 25% of the original amount;
- At age 75, benefits will reduce and additional 15% of the original amount.

Benefits will terminate when the Insured Person retires, at which time the option to convert to an individual life policy will be offered.

The **Long-Term Disability** coverage is available for all eligible full-time employees who regularly work a minimum of 30 hours/week. There is a 90 day elimination period during which no benefits are payable. This period begins on the first day of disability and is satisfied when the 90 days of disability due to the same or related injury or illness have been accumulated within a 180 day period.

The plan pays 60% of the employee's monthly salary, with a minimum monthly benefit of \$100 and a maximum monthly benefit of \$6,000. The maximum benefit period is based on age at the time of disability (see below) **or** employee's Social Security Normal Retirement Age (whichever is later).

<u>Age at Disability</u>	<u>Maximum Benefit Period</u>
Less than age 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

The **Waiting Period** for coverage for Life, AD&D and LTD is 30 days of continuous active work.

Waiver of Coverage: Please sign and date this form where indicated below.

Please Use Ink or Type

GROUP ID:

E. Dependent and Other Insurance Information (Complete ONLY for Dental Enrollment)

List Dependents to be Covered for Dental Benefits (if applicable)

	Last Name	First Name	MI	Sex	Birth Date
EMPLOYEE:					
SPOUSE:					
CHILDREN:					

Are you or any of your eligible dependents covered by any other dental plan? Yes No If YES, please list:

Name of Insured	Insurance Company Name & Phone Number	Employer

Is coverage through other dental plan? Single Family

F. WAIVER OF COVERAGE (Complete ONLY for Waiver of Group Insurance Coverage)

The group program has been offered to me, and after carefully considering its benefits, I have decided:

- (Please indicate your choice) (a) not to enroll myself or dependents in the Program
 (b) not to enroll my dependents in the Program

I understand that if I desire to participate in the Program at some future date, my coverage or my dependents' coverage will not be effective until after Evidence of Insurability is submitted and approved. I understand if a physical examination or further medical information is required, it will be at my own expense.

Employee Signature

Date Signed

Note: A person may be committing insurance fraud if he or she submits an application containing a false or deceptive statement with the intent to defraud (or knowing that he or she is helping to defraud) an insurance company.



TERMINATION OF EMPLOYMENT

LOCATION:

CHURCH NAME: _____

CHURCH ADDRESS: _____

CHURCH NETWORK: _____

CHURCH PHONE # _____

EMPLOYEE INFORMATION:

EMPLOYEE NAME: _____

EMPLOYEE ADDRESS: _____

EMPLOYEE SS# _____

EMPLOYEE DATE OF TERMINATION: _____

RELOCATION INFORMATION IF EMPLOYEE IS MOVING TO ANOTHER CHURCH:

CHURCH NAME: _____

CHURCH ADDRESS: _____

CHURCH NETWORK: _____

CHURCH PHONE # _____

EXPECTED DATE OF RELOCATION: _____

CONTINUED COVERAGE REQUESTED: _____

NOTE: IF AN EMPLOYEE IS MOVING TO ANOTHER CHURCH HE/SHE IS ALSO RESPONSIBLE FOR COMPLETING A NEW ENROLLMENT FORM WITH ALL UPDATED INFORMATION FILLED IN – (A THROUGH D ON THE ENROLLMENT FORM)

THE NEW ENROLLMENT FORM SHOULD BE COMPLETED AT THE NEW CHURCH LOCATION AND SUBMITTED BY THE CHURCH TO AMIA .

FAX: 843-237-4008

EMAIL: phibbs@theamia.org

MAIL: PO BOX 3427 PAWLEYS ISLAND SC 29585