Employee Life, AD&D and Disability Insurance

Compensation Change or Cancel Benefit Form

The following form should be submitted if/when an employee's compensation changes or if an employee is terminated and the life insurance policy benefits need cancelled.

Employer/Church Account Number:	Name of Person Completing the Form:
Employer/Church Name:	Telephone Number:
Employer/Church Address:	Email Address:
Date Form Completed:	Effective Date:

			Clergy Only				
Member Name: List employees who have a compensation change or need policy cancelled	**Last 4 of SSN:**	**Annual Salary (A)**	**Housing or Parsonage Allowance (B)**	**Social Security or Medicate Offset Total (C)**	**Total Annual Compensation (A + B + C)**	**Cancelling Policy? (yes/no)**	**If Cancel, Enter Termination Date**

Please keep a copy of this form for your records and email to **helpdesk@churchbenefits.org** to submit for processing.

Church Benefits Board
4860 Cox Road
Suite 200
Glen Allen, VA 23060

Phone: 770-220-1672
www.churchbenefits.org