Church Benefits Board

Employee Life, AD&D and Disability Insurance
Compensation Change or Cancel Benefit Form

reliance matrix

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:

**If you are cancelling coverage, please complete Employer information, Employee name and cancelling information.*

Employee Name:	Cancelling Policy? Yes ☐ No ☐ If Yes, Employee's last day:
Annual Salary (A):	Housing or Parsonage Allowance (B):
Social Security or Medicare Offset Total (C):	Total Annual Compensation (A + B + C):
Works average of 20 hours per week? Check one Yes ☐ No ☐	Job Title:

Employee Name:	Cancelling Policy? Yes ☐ No ☐ If Yes, Employee's last day:
Annual Salary (A):	Housing or Parsonage Allowance (B):
Social Security or Medicare Offset Total (C):	Total Annual Compensation (A + B + C):
Works average of 20 hours per week? Check one Yes ☐ No ☐	Job Title:

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