The Board of Pensions
of the Presbyterian Church (U.S.A.)

ENR-001
Rev. 1/11

Benefits Plan Membership Application

Please refer to the "Welcome to the Benefits Plan" folder or Pensions.org for more information and annual coverage rates. If you have questions or concerns, please call the Board at 800-773-7752 (800-PRESPLAN).

Both the applicant and a person authorized by the session or employing organization (such as clerk of session, treasurer, business administrator, or financial secretary) must sign and date this form in the Authorization section (J) before coverage is effective. The applicant and the authorized person must be different. The authorized signature on this form confirms that the employing organization agrees to pay all required dues to the Board of Pensions. The authorized signature on this form for lay employee enrollments confirms that the church/employing organization understands that it may not discriminate in its enrollment practices regarding lay employees and that lay employees may not be asked to contribute to payment of dues for medical, pension, death, or disability benefits.

The Board of Pensions continues to bill the employing organization for the selected coverage(s) until the member and the authorized person at the organization instruct the Board to discontinue the member's coverage(s).

Full participation in the Benefits Plan is mandated for ordained ministers serving in called and installed positions. Lay employees and ordained ministers serving in temporary pastoral relationships or specialized ministries must be employed in eligible service at least 20 hours per week. Eligible employment classifications include:

- Ministers of the Word and Sacrament, Presbyterian Church (U.S.A.)
- Exempt or professional lay employees, full time or part time; for example, commissioned lay pastors, those ordained by other denominations, and directors of Christian education
- Non-exempt full-time or part-time lay employees; for example, teachers, aides, secretaries, and custodial staff

Please print legibly in ink, or type information. For all dates, use the month, day, and year.

A Applicant Information

Name ______________________ Soc. Sec. # ______________

(First, Middle, Last) *(This is how your name will appear on all documents from the Board of Pensions.)*

Check one: ☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Rev. *(Ordained minister members must use Dr. or Rev.)*

Home Address

Street address ______________________

City ______________________ State ________ Zip ________

Daytime phone (   ) ____________ Cell phone (   ) ____________ Home phone (   ) ____________

Primary email *(optional)* ______________________

Please note: All written communication will be sent to your **home address** unless there is a mailing address on file. If you wish to add or maintain a mailing address, please complete the Mailing Address section below:

Mailing Address

Street address ______________________

City ______________________ State ________ Zip ________

Citizenship (if other than U.S.A.) ______________ Birth date *(mm/dd/yyyy)* ______________

☐ Male ☐ Female ☐ Single ☐ Married Date of marriage *(mm/dd/yyyy)* ______________

B Spouse and Dependent Children Information

Spouse's full name ______________________

Spouse's Soc. Sec. # ______________________ Spouse's birth date *(mm/dd/yyyy)* ______________________

☐ My spouse is also a member of the Benefits Plan of the Presbyterian Church (U.S.A.) as a result of her/his employment.

☐ I checked the above box and the following applies:
You and your spouse, ______________________, are both ordained ministers of the Word and Sacrament, called to pastoral relationships at the same church, ______________________, and each of you is employed for fewer than 35 hours per week.

Please list all children including all non-custodial dependent children until age 26. Include the appropriate status and relationship codes. For additional dependents, attach a separate sheet of paper.

Status Codes:

DS – permanently disabled age 26 or older and unable to live independently even in a supportive environment. Medical verification will be requested.

Relationship Codes:

D – daughter **SD** – stepdaughter **LW** – legal ward **S** – son **SS** – stepson

Full Name & Address *(address if different from member's address)*	**SSN**	**Birthdate**	**Gender**	**Relationship**	**Status**

Members' spouses and dependents are automatically enrolled for medical coverage in the Traditional program. Members may apply for a dependent coverage waiver for their spouses and dependents in certain circumstances. Please visit Pensions.org for more information.

C Previous Service

Before the effective date of plan membership, were you employed by any Presbyterian Church (U.S.A.) organization or church where you were scheduled to work 20 hours/week or more? ☐ Yes ☐ No

If you were, list all services when you were **not** covered under the Benefits Plan:

Organization/Church	**Address**	**Dates served** *(mm/dd/yyyy)*	
		From	**To**

Ministers of the Word and Sacrament:

Date ordained in the Presbyterian Church (U.S.A.) *(mm/dd/yyyy)* ______

Name of presbytery when ordained ______

Current presbytery ______

If transferred from another denomination, please name ______

Date received into the Presbyterian Church (U.S.A.) *(mm/dd/yyyy) (must attach written presbytery verification)* ______

By which presbytery? ______

D Effective Dates

Date you began working 20 hours/week or more *(mm/dd/yyyy)* ______

As a condition of your employment, were you required to complete a waiting period before joining the Benefits Plan? *(maximum waiting period is one year)*

☐ No ☐ Yes If "yes," give dates of the waiting period. From *(mm/dd/yyyy)* ______ to *(mm/dd/yyyy)* ______.

Requested effective date for Benefits Plan membership *(mm/dd/yyyy)* ______

Lay employees and ordained persons serving in non-installed positions: If the proposed effective date of benefits is more than **31 days** before the postmarked date of your application, membership begins on the postmarked date.

Ordained persons serving in called and installed positions: Effective date of benefits is the effective date of the call but no more than **12 months** before the postmarked date of this form.

E Service Information

Organization/Church name ______ PIN ______

Address ______

City ______ State ______ Zip ______

Presbytery ______ Synod ______

Phone ( ) ______ Fax ( ) ______ Email ______

Position title ______ Position code *(see below)* ______

Lay Participation: ☐ exempt lay member* ☐ non-exempt lay member*

Number of hours scheduled to work per week *(excluding overtime)* ______

For plan participation, full time is 35 hours or more per week.

* Visit the Department of Labor Web site at http://www.dol.gov for classification information.

All lay employees, except commissioned lay pastors, use 788 as the position code; commissioned lay pastors use 107. All others, please use the appropriate code in the Authorized Ecclesiastical Occupation Designations in the General Assembly Minutes. Parish Associate is not an eligible title for Benefits Plan participation.

Some frequently used codes are:

101 Pastor or Co-Pastor
103 Associate Pastor
105 Interim Pastor or Associate
106 Stated Supply

107 Commissioned Lay Pastor
108 Temporary Supply
191 Designated Pastor
301 Organizing Pastor

791 Specialized Ministry
Use 791 only if there is no code associated with the Specialized Ministry position/title in the GA Minutes book.

F Annual Salary Information

Salary information determines Medical Plan deductible and copayment maximums.

Please enter annual amounts or zero if not applicable.

1. Cash salary *(including employee contributions to 403(b)(9) plans; tax-sheltered annuity plans; unvouchered book, car, and study allowances; vacation pay and overtime)* 1 $____________
2. Housing allowance, utilities, and furnishings allowances 2 $____________
3. Employing organization contributions to 403(b)(9) plans, tax-sheltered annuity plans and equity allowances 3 $____________
   (Effective 1/1/08, matching contributions to the Board's Retirement Savings Plan should not be included.)
4. Bonus *(will be included for the current year only; if continuing, you will need to report annually)* 4 $____________
   Year in which bonus is paid ______________________
5. SECA *(For reimbursement in excess of 50% of the minister's SECA tax obligation)* 5 $____________
6. Other allowances *(including copayment and medical expense reimbursement allowances)* 6 $____________
   Do not include expenses reimbursed through vouchers or Benefits Plan dues.
7. Manse amount *(must be at least 30% of Lines 1-6 for members residing in a manse)* 7 $____________
8. **Total Annual Effective Salary** ***(total of Lines 1-7)*** 8 **$**____________

Dues are computed and benefits are determined on this amount (subject to minimums and maximums).

You may use the Total Effective Salary Calculator and the Dues Calculator on Pensions.org to determine the impact on dues.

Effective Salary is any compensation a member receives during a plan year from an employing organization. For more information, see *Understanding Effective Salary* booklet available on Pensions.org.

G Selection of Coverage

Refer to schedule for dues and subscription costs.

Check one:

☐ **Full Participation** includes medical benefits, pension, death, and disability coverage.

☐ **Limited Participation** *(check one)*

- ☐ Medical, death, and disability; not available for ministers serving churches in installed positions. After three years of limited participation, employees must be enrolled for full participation.
- ☐ Medical only; **only available** to ordained ministers in certain specialized ministries who must also **complete Sections K and L**.
- ☐ Pension, death, and disability only; **only available** to ordained ministers in certain specialized ministries who must also **complete Sections K and L**.

HMO Option

This option is only available to members who work or reside in the Mid-Kentucky Presbytery or Puerto Rico.

To determine if you are eligible to participate in an HMO offered by the Benefits Plan, please refer to the Healthcare Coverage booklet included with your "Welcome to the Benefits Plan" folder. If your employing organization is within a listed presbytery, you are eligible.
Did you receive HMO information? ☐ Yes ☐ No

Would you like to consider participating in an HMO? ☐ Yes ☐ No

Optional Coverage

Optional Dental Benefit

Please refer to the Healthcare Coverage booklet for restrictions and eligibility requirements. To elect this option, please check one:

☐ Yes, I am interested in enrolling. Please send me information on the options available and an application for completion.
Visit Pensions.org for more information on the Optional Dental Benefits, including eligibility and coverage options and an online rate checker tool.

☐ No, I am not interested in enrolling at this time. I understand that I will only be able to enroll at a later date if I have a life-change event or if there is an open enrollment as outlined in the Healthcare Coverage booklet. I also understand that I may have a 12-month limitation on dental services.

Other Optional Programs

To enroll in optional coverage noted in the "Welcome to the Benefits Plan" folder, please complete and return the appropriate forms. You may elect to participate in long-term care insurance, supplemental death benefits, Retirement Savings Plan, and optional supplemental disability benefits (see salary restrictions).

H Previous Coverage

Did you and/or your dependents have medical coverage under a previous employer/insurance carrier? ☐ Yes ☐ No

If "yes," please submit a certificate of creditable coverage. The certificate is provided by an employer/insurer to show the dates of previous medical coverage. It is required to determine the time to be credited for any pre-existing condition limitations that may otherwise apply. Expenses for treatment of pre-existing conditions will not be covered for the first 12 months; however, prior coverage documented by a certificate will reduce or eliminate the limitation period. Children under the age of 19 are not subject to the pre-existing limitation period.

(Check one)

☐ I am including my certificate of creditable coverage with this application.

☐ I am sending my certificate of creditable coverage separately.

I Other Medical Coverage Information To Coordinate Benefits

If you, your spouse, or dependents are or have been covered under any other group medical plan(s) during the previous 12 months, including coverage for retirees, complete this section. You may call the Board for more information about coordinating your other coverage with plan coverage.

Member applicant

Coverage in the name of ______________________________

Policy covered *(Check all that apply.)* ☐ applicant ☐ spouse ☐ children

Coverage through *(employer name)* ______________________________

Phone ( ) ______________________________

Insurance carrier/Medicare ______________________________

Phone ( ) ______________________________

Group number ______________ Policy or ID# ______________

Effective date *(mm/dd/yyyy)* ______________ End date of coverage, if applicable *(mm/dd/yyyy)* ______________

Check all that apply: ☐ Medical ☐ Dental ☐ Prescription drug benefits ☐ Active ☐ Retired ☐ COBRA

If you were covered by more than one carrier in the previous 12 months, complete this section:

Additional carrier(s)

Insurance carrier/Medicare ______________________________

Phone ( ) ______________________________

Group number ______________ Policy or ID# ______________

Effective date *(mm/dd/yyyy)* ______________ End date of coverage, if applicable *(mm/dd/yyyy)* ______________

Spouse or Dependent Children

Coverage in the name of ______________________________

Policy covered *(Check all that apply.)* ☐ applicant ☐ spouse ☐ children

Coverage through *(employer name)* ______________________________

Phone ( ) ______________________________

Insurance carrier/Medicare ______________________________

Phone ( ) ______________________________

Group number ______________ Policy or ID# ______________

Effective date *(mm/dd/yyyy)* ______________ End date of coverage, if applicable *(mm/dd/yyyy)* ______________

Check all that apply: ☐ Medical ☐ Dental ☐ Prescription drug benefits ☐ Active ☐ Retired ☐ COBRA

If you were covered by more than one carrier in the previous 12 months, complete this section.

Additional carrier(s)

Insurance carrier/Medicare ______________________________

Phone ( ) ______________________________

Group number ______________ Policy or ID# ______________

Effective date *(mm/dd/yyyy)* ______________ End date of coverage, if applicable *(mm/dd/yyyy)* ______________

J Authorization

Applicant authorization, **except Specialized Ministry applicants who must complete Sections K and L**.

I confirm that the information provided in this application is true, correct, and complete to the best of my knowledge. In accordance with the Benefits Plan, I agree to furnish any information the Board needs in connection with any medical or dental claim for a family member or me, including information about any other group medical coverage. I confirm that my child(ren) does not have access to employer-sponsored coverage. If this changes, I will notify the Board.

I hereby consent to the release of my personal health information and, if applicable, that of my eligible family to the Board's representatives and agents, including, without limitation, ActiveHealth®, CIGNA Behavioral Health, Express Scripts, Highmark, and their successors and assignees, for the purpose of paying claims and Medical Plan operations.

Applicant's signature *(required)* ______________ Date *(mm/dd/yyyy)* ______________

Spouse's signature ______________ Date *(mm/dd/yyyy)* ______________

Employing Organization Authorization ***(cannot be the applicant)***

On behalf of the employing organization, I certify that we have confirmed eligibility for plan benefits for the spouse and the children as defined by the Benefits Plan of the Presbyterian Church (U.S.A.). I confirm the accuracy of the information concerning benefits selection and agree to pay all required dues to the Board of Pensions by the due date.

Authorized person's name *(print)* ______________________________

Signature *(required)* ______________ Date *(mm/dd/yyyy)* ______________

Title ______________ Daytime phone ( ) ______________

Please Remember:

- **To ensure prompt processing, please complete this form carefully and include all of the appropriate signatures. Applications submitted without the appropriate signatures are returned, which may result in delayed coverage.**
- **As part of your application, the Board also requires the completion of the attached Death Benefits Beneficiary Designation form.**
- **If you choose to enroll in the Supplemental Death benefit, you will also need to complete the Supplemental Death Benefit Beneficiary form**.

K Specialized Ministry Applicants only

(This section is for PC(USA) ministers who are not serving PC(USA) churches or associated employing organizations.)

Applicant Authorization

I confirm that the information provided in this application is true, correct, and complete to the best of my knowledge. I confirm that my child(ren) does not have access to employer-sponsored coverage. If this changes, I will notify the Board.

If my employing organization requires participation in another group medical or pension plan as a condition of employment, I understand that I must complete the Specialized Ministry Waiver of Coverage section of this form and submit the verification it requires.

In accordance with the Benefits Plan, I agree to furnish any information the Board needs in connection with any medical or dental claim for a family member or me, including information about any other group medical coverage.

I hereby consent to the release of my personal health information and, if applicable, that of my eligible family to the Board's representatives and agents, including, without limitation, ActiveHealth, CIGNA Behavioral Health, Express Scripts, Highmark, and their successors and assignees, for the purpose of paying claims and Medical Plan operations.

I understand that, before I can be enrolled for benefits, I must provide a letter from my presbytery validating this service as an extension of ministry.

Applicant's signature *(required)* ____________________ Date *(mm/dd/yyyy)* __________

Spouse's signature ____________________ Date *(mm/dd/yyyy)* __________

My benefits dues will be paid ☐ by me or ☐ by my employing organization.

Billing account name ____________________

Address ____________________

City ____________________ State __________ Zip __________

Employing Organization Authorization ***(cannot be the applicant)***

On behalf of the employing organization, I certify that we have confirmed eligibility for plan benefits for the spouse and the children as defined by the Benefits Plan of the Presbyterian Church (U.S.A.). I confirm the accuracy of the information concerning benefits selection and agree to pay all required dues to the Board of Pensions by the due date.

Authorized person's name *(print)* ____________________
(cannot be the applicant)

Signature *(required)* ____________________ Date *(mm/dd/yyyy)* __________

Title ____________________ Daytime phone (   ) __________

L Specialized Ministry Waiver of Coverage

Only for those who want to opt out of pension, medical, death, or disability benefits.

I hereby certify that

- I am engaged in a validated ministry of the Presbyterian Church (U.S.A.) and, as a condition of my employment, am required to participate in the benefits plan of my employer:

Name of employing organization ____________________

Address ____________________

City ____________________ State __________ Zip __________

Phone (   ) ____________________

- My employer, through a program other than the Benefits Plan of the Presbyterian Church (U.S.A.), will provide the following coverage(s), which are sufficient for my purposes:
  - ☐ Pension, Death, and Disability benefits
  - ☐ Medical benefits
- I hereby waive for my family and me these coverage(s) from the Benefits Plan of the Presbyterian Church (U.S.A.):
  - ☐ Pension, Death, and Disability benefits
  - ☐ Medical benefits
- I understand that by waiving coverage through the Benefits Plan of the Presbyterian Church (U.S.A.), I am relinquishing substantial benefits to which I might otherwise be entitled. I relieve The Board of Pensions of the Presbyterian Church (U.S.A.) from any and all responsibility/liability for the loss of benefits which I am waiving.
- I understand that if I complete my career in a non-participating church-related service, and I completed 20 years or more of eligible service, I and my eligible dependents can subscribe for retiree medical coverage if I meet all of the eligibility requirements for this coverage. I also understand that if my ministry service is in a country with national healthcare, I will not be eligible for retiree medical coverage when I retire unless I meet all of the eligibility requirements for this coverage as follows:
  - covered under the Medical Plan as of the date of initial retirement
  - had a minimum of five (5) years of plan participation
  - if Medicare eligible, participating in both Part A and Part B of Medicare
- I understand that future election of coverage in the Benefits Plan for the option(s) which I have waived is subject to the re-entry rules and policies of the Benefits Plan of the Presbyterian Church (U.S.A.).
- I understand that I must provide a letter from my presbytery to verify that I must participate in my employer's benefits plan.

Applicant's signature *(required)* ______________________ Date *(mm/dd/yyyy)* ____________

Applicant's name *(print)* ______________________

The Benefits Plan considers a minister of the Word and Sacrament employed by an organization not under the jurisdiction of the Church as being in a "specialized ministry" when such employment is validated by the member's presbytery.

A member in a specialized ministry required to participate in her/his employer's group benefits plan as a condition of employment may waive part or all of the Benefits Plan coverage.

The employee noted above is mandated to participate in the following coverages as a condition of employment:

☐ Pension, Death, and Disability ☐ Medical

Signature of Employer *(required)* ______________________ Date *(mm/dd/yyyy)* ____________
(cannot be the applicant)

Print name ______________________

Title ______________________

Death Benefits Beneficiary Designation

Use this form to designate the beneficiary or beneficiaries to receive death benefits **(Salary Continuation Benefit)** payable at your death. To change or revoke this designation, send a new form to the Board of Pensions. You are eligible for this benefit if you are an active or disabled member, or if you are a terminated vested or retired member who meets the Rule of 70. *See the Death Benefits product sheet (PTS-609), available at Pensions.org, for further information.*

A Your Personal Information

Name *(first, middle, last)* Soc. Sec. #

B Beneficiary Designation

You may name any person, institution, or trust as a beneficiary. You must name each beneficiary individually; a designation such as “all my children equally” is unacceptable. Include the name and date of any trust and the trustee's name. You may select primary and secondary beneficiaries.

If any primary beneficiaries predecease you, the benefit is divided proportionately among the surviving primary beneficiaries unless you specifically designate otherwise. For example, if you name your adult children as your primary beneficiaries and one of them predeceases you, the benefit will be distributed proportionately to the remaining surviving children. If no allocations are specified, the benefit will be divided equally among the primary beneficiaries.

In the event that a beneficiary designation is found to be incomplete or uncertain at the time of your death, the benefit will be paid to your estate.

If none of your primary beneficiaries survives you, then your secondary beneficiaries will receive the benefit in the allocations you specify. If no allocations are specified, the benefit will be divided equally among your secondary beneficiaries.

If you are naming more than one primary and/or secondary beneficiary, please specify the percentage of your benefit each beneficiary should receive. The percent share for primary and secondary beneficiaries should each **total 100 percent (use whole percentages: e.g., 34%, not 33.3%).** The same person cannot be listed as the primary AND secondary beneficiary.

1. Your primary beneficiary

Name the primary beneficiary or beneficiaries to receive any benefits due under the Salary Continuation Benefit in the event of your death.

Full Name *(of person, estate, trust, or other)*	Full Soc. Sec. # *(if person)*	Relationship *(if person)*	% Allocation
Executor's or trustee's name *(if estate or trust)*	Trust date *(if trust)*	Birth date *(of beneficiary)*	
Address *(of person beneficiary, executor, trustee, or other)*			
City		State	Zip

Full Name *(of person, estate, trust, or other)*	Full Soc. Sec. # *(if person)*	Relationship *(if person)*	% Allocation
Executor's or trustee's name *(if estate or trust)*	Trust date *(if trust)*	Birth date *(of beneficiary)*	
Address *(of person beneficiary, executor, trustee, or other)*			
City		State	Zip

Full Name *(of person, estate, trust, or other)*	Full Soc. Sec. # *(if person)*	Relationship *(if person)*	% Allocation
Executor's or trustee's name *(if estate or trust)*	Trust date *(if trust)*	Birth date *(of beneficiary)*	
Address *(of person beneficiary, executor, trustee, or other)*			
City		State	Zip

Total primary beneficiary allocation: 100%

Note: If you need additional space to designate beneficiaries, please attach a separate sheet with your name, Social Security number, signature, date, the words "Salary Continuation Benefit," and information about your additional primary and/or secondary beneficiaries, including the allocation percentage.

2. Your secondary beneficiary

Your secondary beneficiary or beneficiaries receive payment only if all primary beneficiaries predecease you.

Full Name *(of person, estate, trust, or other)*	Full Soc. Sec. # *(if person)*	Relationship *(if person)*	% Allocation
Executor's or trustee's name *(if estate or trust)*	Trust date *(if trust)*	Birth date *(of beneficiary)*	
Address *(of person beneficiary, executor, trustee, or other)*			
City		State	Zip
Full Name *(of person, estate, trust, or other)*	Full Soc. Sec. # *(if person)*	Relationship *(if person)*	% Allocation
Executor's or trustee's name *(if estate or trust)*	Trust date *(if trust)*	Birth date *(of beneficiary)*	
Address *(of person beneficiary, executor, trustee, or other)*			
City		State	Zip

Total secondary beneficiary allocation: 100%

C Authorization

I understand that this beneficiary designation will become effective when the Board of Pensions receives and approves this form and that it will remain in effect until a new Death Benefits Beneficiary Designation form signed by me is received at the Board of Pensions.

I further understand that in the event of a dispute as to the eligible beneficiaries at the time of my death, the determination of the Board of Pensions will be final and conclusive. I do hereby, for myself, my beneficiaries, heirs, executors, and administrators, release the Board of Pensions from any and all liability for any and all payments that may be made as a result of and in accordance with this Death Benefits Beneficiary Designation form.

I certify that the information on this form is complete and accurate.

Signature of Member *(required)* Date *(mm/dd/yy)*

Mail or FAX this completed form to:

The Board of Pensions of the Presbyterian Church (U.S.A.)
2000 Market Street, Philadelphia, PA 19103-3298
800-773-7752 (800-PRESPLAN) FAX: 215-587-6215
Pensions.org