The Pension Boards
United Church of Christ, Inc.
WHERE FAITH AND FINANCE INTERSECT

UCC Medicare Advantage Plan with Rx and Dental Benefits Plan Enrollment Application

EMPLOYER ID: _____ [ ] NEW EMPLOYER
MEMBER ID: _____ [ ] EXISTING MEMBER*

*If you are an existing member and/or annuitized your previous account, please provide your Member ID number above, and your name in the Personal Information section below.

PERSONAL INFORMATION

SSN: _____ Gender: [ ] M [ ] F Date of Birth: _____/_____/_____ Title: [ ] Rev. [ ] Dr.

Relationship Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Civil Union [ ] Domestic Partner

Name of Member (last, first, middle initial): _____

Address Line 1: _____ Address Line 2: _____

Address Line 3: _____ City _____ State _____ Zip Code _____

Cell Phone: (____) _____ - _____ Home Phone: (____) _____ - _____ Email: _____

SPOUSE / PARTNER INFORMATION (if applicable)

Name of Spouse / Partner (last, first, middle initial): _____

SSN: _____ Date of Birth: _____/_____/_____ Date of Marriage: _____/_____/_____

EMPLOYEE INFORMATION

Employee Type: [ ] Clergy [ ] Lay For Clergy Only - Ordination Date: ____ / ____ / _____

Employment Type: [ ] Actively Working [ ] Retiree Date of Hire: _____/_____/_____

MEDICARE PARTICIPATION

What plan are you enrolled in? Medicare Part A [ ] Yes [ ] No Medicare Part B [ ] Yes [ ] No
What plan is your spouse enrolled in? Medicare Part A [ ] Yes [ ] No Medicare Part B [ ] Yes [ ] No

Note: A copy of your or your spouse's Medicare card(s) must be submitted with this application.

PLAN(S) ELECTED

Medical: [ ] Medicare Advantage Plan
Dental: [ ] Dental Plan

DEPENDENT(S) INFORMATION

1. Name of Dependent (last, first, middle initial): _____ Gender: [ ] M [ ] F

SSN: _____ Date of Birth: _____/_____/_____ Relationship: _____

2. Name of Dependent (last, first, middle initial): _____Gender: [ ] M [ ] F

SSN: _____ Date of Birth: _____/_____/_____ Relationship: _____

3. Name of Dependent (last, first, middle initial): _____ Gender: [ ] M [ ] F

SSN: _____ Date of Birth: _____/_____/_____ Relationship: _____

4. Name of Dependent (last, first, middle initial): _____ Gender: [ ] M [ ] F

SSN: _____ Date of Birth: _____/_____/_____ Relationship: _____

[ ] Additional Dependent(s): check if applicable, and list information on a separate sheet of paper and attach to this form.

EMPLOYEE (Member) AGREEMENT

By signing this form, I hereby enroll in the UCC Medicare Advantage Plan with Rx and/or the Dental Benefits Plan as indicated above. If my status or my dependent's status changes, I agree to notify the Pension Boards immediately.

Self-Pay Members: Billing Preference (Please choose one):

[ ] I agree to have my monthly dental premium deducted from my monthly annuity payment. Your monthly annuity benefit must be large enough to accommodate this deduction. If not, you will receive a monthly bill instead. Minimum threshold to pay out is at least $50 monthly in annuities.

[ ] I agree to accept a monthly E-bill notice which will instruct me to login and pay online via www.pbucc.org.

Member Signature: _____ Date: _____/_____/_____

EMPLOYER INFORMATION

Employer signature is not required for self-pay Medical Benefits.

Employer signature is required if employee or dependent(s) is eligible for UCC Medicare Advantage Plan with Rx Plan. Contributions are to be paid by the employer. If the employer employs less than 20 employees, then a **Small Employer Exemption (SEE) form** must be completed and submitted with this application to participate in the UCC Medicare Advantage Plan with Rx Plan.

Employer signature is required if employee is eligible for UCC Medical Benefits for non-Medicare eligible or any insurance benefit offered by PBUCC.

If you are a new Employer to the Pension Boards, you must complete a **Church Plan certification form** and **Qualified Church-Controlled Organization (QCCO) form** and submit it to the Pension Boards at the address listed below or attach the forms to the application for enrollment.

By signing this form, the Employer, by its duly authorized officer or other representative, hereby agrees to the provisions, rules, and procedures with respect to eligibility and contributions as indicated on this application, and in alignment with the Employer Adoption Agreement.

EMPLOYER INFORMATION – **continued**

Employer ID: _____
Employer Name: _____

Employer Address: _____ City_____ State _____ ZIP_____

Signature of authorized officer: _____ Date: _____/_____/_____

Please return this signed and completed form by email to: info@pbucc.org; by fax: 212.729.2701; or mail to: Pension Boards-UCC, 475 Riverside Drive, Suite 1020, New York, NY 10115.