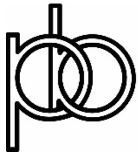

The Pension Boards
United Church of Christ, Inc.
WHERE FAITH AND FINANCE INTERSECT

Medical and Dental Benefits

Annual Change Form

MEMBER ID: _______________

PERSONAL INFORMATION

SSN: ___________________ Date of Birth: _________________ Gender: [ ] M [ ] F Status: __________________

Name of Employee (last, first, middle initial): ____Title: ______

Address: _______________________________________ City_________________ State _____ ZIP____________

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

PLAN CHANGE(S) REQUESTED

The deadline to make changes is December 1 of each year. Requested changes will take effect January 1 of the following year.

Medical

[ ] I wish to change my medical plan option:

(check one only) [ ] Plan A [ ] Plan B [ ] Plan C [ ] HDHP

[ ] I wish to cancel my medical plan benefits as of: _____________________

Dental

[ ] I wish to continue current dental coverage.

[ ] I wish to cancel my dental plan benefits as of: ______________________

ADD OR REMOVE DEPENDENT(S)

Any dependent added after the initial 90 days of eligibility will also need to complete and return the Statement of Health Form.

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

SSN: ___________________ Date of Birth: _________________ Relationship: ______________________

[ ] Add or [ ] Delete

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

SSN: ___________________ Date of Birth: _________________ Relationship: ______________________

[ ] Add or [ ] Delete

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

SSN: ___________________ Date of Birth: _________________ Relationship: ______________________

[ ] Add or [ ] Delete

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

SSN: ______________________ Date of Birth: ____________________ Relationship: _________________________

[ ] Add or [ ] Delete

EMPLOYER INFORMATION

Employer signature is required if UCC Medical and Dental Benefits Plan contributions are to be paid by the employer.

Employer ID: ___________________

Employer Name: ____

Employer Address: _______________________________________ City____________________ State _____ ZIP_____________

Signature of authorized officer: _____________________________________ Date: ___________________

SIGNATURE

By signing this form, I hereby change my enrollment in the UCC Medical and Dental Benefits Plan as indicated above.

Employee Signature ____________________________________ 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.