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

UCC Medicare Advantage Plan with Rx and Dental Benefits Enrollment Application

MEMBER ID: _____

PERSONAL INFORMATION

SSN: _____ Date of Birth: _____ Title: _____

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

Address: _____ City_____ State _____ ZIP_____

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

Relationship Status: [ ] Single [ ] Married [ ]Divorced [ ] Widowed [ ] Civil [ ] Domestic Partnership

Date of marriage or domestic partnership (only if enrolling spouse/partner): _____

Ordination date (if applicable): _____ Is this your first UCC employment? [ ] Yes [ ] No

Do you or any member of your family have other dental coverage? [ ] Yes - Carrier: _____ [ ] No

---

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

Dental: (check one only)
[ ] Dental 2000 Plan [ ] Standalone Dental (only if no Medical is selected)

DEPENDENT(S) INFORMATION

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

SSN: _____ Date of Birth: _____ Relationship: _____

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

SSN: _____ Date of Birth: _____ Relationship: _____

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

SSN: _____ Date of Birth: _____ Relationship: _____

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.

EMPLOYER INFORMATION

Employer signature is required if UCC Medicare Advantage Plan with Rx and Dental Benefits Plan contributions are to be paid by the employer. Your employer employs less than 20 employees and completed a Small Employer Exemption form to participate in this plan.

Employer ID: _____ Date of hire: _____ Hours worked per week: _____

Employer Name: _____

Employer Address: _____ City_____ State _____ ZIP_____

Signature of authorized officer: _____ Date: _____

ADDITIONAL INFORMATION

Late applicants for the Medical Plan will need to provide a completed Statement of Health form for themselves and each dependent applying for coverage. Late applicants for the Dental Plan will need to apply for the UCC Dental 750 Plan during the annual open enrollment held in October each year, and benefits will begin on January 1 of the following year.

SIGNATURE

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

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.