The Pension Boards
United Church of Christ, Inc.

Medicare Supplement Enrollment Application

PERSONAL INFORMATION			
Social Security Number	Name of employee *(last, first, middle initial)*		
Address *(number and street)*		City/State/ZIP	
Telephone number *(with area code)* ( ) –		E-mail address @	
Relationship Status: ☐ Single ☐ Widowed ☐ Married ☐ Civil Union ☐ Divorced ☐ Domestic Partnership	Title: ☐ Ms. ☐ Mr. ☐ Rev. ☐ Dr.	Do you or any member of your family have other medical coverage? ☐ Yes ☐ No If yes, list carrier name and address:	

PROVIDE EMPLOYEE AND DEPENDENT(S) INFORMATION BELOW
(Use additional sheet if necessary)

Name (last, first, middle initial)	Relationship to participant	Date of birth (mm/dd/yr)	Social Security Number	Gender
	Self		**XXX-XX-XXXX**	
	Spouse/Partner			

Employee: *Please read and sign below. (Unsigned applications will be returned.)*
I certify that the adult child(ren) listed above is (are) not eligible to enroll in an eligible employer-sponsored health plan. If my status or my dependent's status changes, I agree to notify the Pension Boards immediately. I hereby enroll in the UCC Medical Benefits Supplement Health Plan.

Are you enrolled in Medicare Part A: ☐ Yes ☐ No Medicare Part B: ☐ Yes ☐ No

SIGNATURE

Employee signature	Date

EMPLOYER INFORMATION
(if applicable, see reverse)

Name of employer	Date of hire	Hours worked per week
Address (number and street)	City/State/ZIP	
Employer Signature	Date signed	

Please return to the Pension Boards at the address indicated above, and retain a copy for your records.

MSEA 2017 11-2016

INSTRUCTIONS

Please complete all required information and sign your enrollment application. Any incomplete, unsigned application will be returned and not accepted by the Pension Boards.

Eligible employees must enroll in the UCC Medicare Supplement Health Plan within 90 days of initial UCC employment.

"Employee" means the primary subscriber who is enrolled in and covered by the UCC Medicare Supplement Health Plan.

"Dependent(s)" includes the spouse or domestic partner and children.

Employer Signature is required if UCC Medicare Supplement Health Plan contribution rates are paid by the employer.

Please be sure to list all dependents to be covered under your policy with the UCC Medicare Supplement Health Plan. Use an additional sheet of paper if necessary.

QUESTIONS? NEED ASSISTANCE?

The Pension Boards staff is available to assist you in this important process. Please feel free to contact a Member Services Representative toll-free at **1.800.642.6543, Option 6**, or by e-mail at **info@pbucc.org**.

Please return to the Pension Boards at the address indicated above, and retain a copy for your records.

475 Riverside Drive, Room 1020 New York, NY 10115 | 800.642.6543 | fax: 212.729.2701 | info@pbucc.org | www.pbucc.org