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

Life Insurance / Disability Insurance Enrollment Application Form

MEMBER ID: _____

PERSONAL INFORMATION

SSN: _____ Date of Birth: _____ Gender: [ ] M [ ] F Status: _____

Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widow Date of Marriage: ____ / ____ / _____

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

Address: _____ City_____ State _____ ZIP_____

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

SPOUSE / PARTNER INFORMATION (if applicable)

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

SSN: _____ Date of Birth: _____

SALARY INFORMATION

Cash Salary: _____ Parsonage or Housing Allowance Value (if applicable): _____

Total Cash Salary plus Housing Allowance (Salary Basis) _____

If you serve more than one UCC-related employer, please put additional data on a separate sheet.

BENEFICIARY INFORMATION (MUST EQUAL 100%):

1. Name (last, first, middle initial): _____ Relationship to participant: _____

SSN: _____ Date of Birth: _____ Gender: [ ] M [ ] F

Life Insurance: [ ] Primary _____% [ ] Secondary _____ %

2. Name (last, first, middle initial): _____ Relationship to participant: _____

SSN: _____ Date of Birth: _____ Gender: [ ] M [ ] F

Life Insurance: [ ] Primary _____% [ ] Secondary _____ %

3. Name (last, first, middle initial): _____ Relationship to participant: _____

SSN: _____ Date of Birth: _____ Gender: [ ] M [ ] F

Life Insurance: [ ] Primary _____% [ ] Secondary _____ %

3. Name (last, first, middle initial): _____ Relationship to participant: _____

SSN: _____ Date of Birth: _____ Gender: [ ] M [ ] F

Life Insurance: [ ] Primary _____% [ ] Secondary _____ %

AGREEMENT

It is agreed between the parties hereto that payments at the annual rate of 1.5% of Salary Basis will be made to the Pension Boards by the undersigned on the following basis for Group Life Short-Term and Long-Term Disability Benefits. Please check one:

[ ] By the employer at 1.5% of Salary Basis

[ ] By the member (personal billing) at 1.5% of Salary Basis

Employer Name: _____ Employer ID: _____

Employer Address: _____ City_____ State _____ ZIP_____

Employer Telephone: (____) _____ - _____ Date of Hire: _____

ADDITIONAL INFORMATION

Is this your first UCC employment in which you are working at least 20 hours per week? [ ] Yes [ ] No
If no, please list your UCC employer below.

Employer Name: _____ City_____ State _____ ZIP_____

First date of employment: _____ Last date of employment: _____

If you have been employed over 90 days with your current employer or did not participate in the UCC Life Insurance and Disability Income (LIDI) Benefit Plan during your last eligible employment, you must complete a Statement of Health form.

SIGNATURE

I desire to become insured, until further notice, for the UCC Life Insurance and Disability (LIDI) Benefit Plan as described in the booklet, Highlights of Your UCC Life Insurance and Disability (LIDI) Benefit Plan. I have read the booklet and based on the eligibility requirements to participate, verify that I am a full-time employee working 20 or more hours per week. I agree that provisions will be made for the payment of necessary fees on my behalf.

Employee's Signature _____ Date: _____

Employer's 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.