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

Annuity Plan Membership and Other Benefit Plans

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. Only complete the section(s) of the form that are being changed or updated. Your Employer must sign the form.

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: _____ City_____ State _____ ZIP_____

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: _____/_____/_____

[ ] Add spouse / partner as health benefit dependent

EMPLOYEE INFORMATION

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

Employment Type: [ ] Full Time [ ] Part Time [ ] Contract Average Hours Worked Per Week: _____

Conference: _____ Self Employed: [ ] Y [ ] N

Date of Hire: _____/_____/_____

COMPENSATION/SALARY INFORMATION

Salary Effective Date: ____ / ____ / _____

Annual Base Salary: $ _____

Annual Housing Allowance: $ _____

Annual Base Salary plus Housing Allowance: $ _____

Please note: Any changes to salary will be entered on the first day of the month following the Salary Effective Date.

OPTIONAL BENEFIT PLANS

Information about our additional plans is available online. Visit our website at **www.pbucc.org** and select the Pension & Benefits option.

Please select one or more options. NOTE - FOR MEDICAL AND DENTAL BENEFITS DEPENDENT INFORMATION IS REQUIRED – SEE PAGE 3

[ ] **MEDICAL**** [ ] Plan A [ ] Plan B [ ] Plan C **Effective Date** _____/_____/_____
[ ] UCC Medicare Advantage Plan with Rx

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 for enrollment into the UCC Medicare Advantage Plan with Rx.

******Participants may apply for Medical plan coverage within 90 days of date of hire. After 90 days of hire, you are required to complete a **Medical Statement of Health form**. The UCC Medicare Advantage Plan with Rx does not require a Statement of Health form. The completed statement of health form(s) must be returned along with your Annuity Plan Membership and Other Benefit Plans Form.

[ ] **DENTAL** [ ] Dental Plan (if Medical coverage is selected) **Effective Date** _____/_____/_____
[ ] Dental Plan Standalone (only if no Medical Coverage is selected)

[ ] **LIFE INSURANCE AND DISABILITY INCOME BENEFITS**** **Effective Date** _____/_____/_____
Is this your **initial** UCC employment in which you are working at least 20 hours per week? __ Yes or __ No
[ ] Basic Life Insurance ***
[ ] Optional Additional Life *** [ ]10 [ ]20 [ ]30 [ ]40 [ ]50 [ ]60 [ ]70 [ ]80 [ ]90 [ ]100
[ ] Optional Spouse Death Benefit *** [ ]10 [ ]25
[ ] Optional Child Death Benefit *** [ ]5 [ ]10

Participants applying for Life and Disability Income Benefits after 90 days of initial date of hire, are also required to complete a **MetLife Statement of Health form. The completed statement of health form(s) must be returned along with your Annuity Plan Membership and Other Benefit Plans Form.

***** For Life Insurance and Disability only:** The completed **Life Insurance and Disability Income (LIDI) MetLife Enrollment Change** needs to be returned along with your Annuity Plan Membership and Other Benefits Form.

[ ] **FLEXIBLE SPENDING ACCOUNT (FSA):** New members can enroll within the first 30 days of their employment. Existing members enroll during the open enrollment period at the end of each calendar year for the following year. The minimum amount you can elect is $100.

Effective Date _____/_____/_____

[ ] I elect Medical Reimbursement [ ] I elect Dependent Reimbursement

Annual Salary reduction: $_____ Medical $_____ Dependent
(2023 IRS Max=$3,050) ***(2023 IRS Max=$5,000)***
[ ] My health coverage is through my spouse's/partner's UCC Health Plan.

_____
Name of spouse/partner and member ID

DEPENDENT INFORMATION FOR INSURANCE – If you are applying for Medical and Dental Benefits, Dependent Information is required for enrollment.

1. Coverage: [ ] Medical [ ] Dental

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

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

2. Coverage: [ ] Medical [ ] Dental

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

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

3. Coverage: [ ] Medical [ ] Dental

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

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

4. Coverage: [ ] Medical [ ] Dental

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

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

[ ] Additional Dependent Information for Insurance: Check if applicable, and list information on a separate sheet of paper and attach to this form.

PENSION (EMPLOYER) CONTRIBUTIONS

Please note: Any changes to contribution amounts will be entered on the first day of the month following the Effective Date.

Employer contributions: _____% or $_____ Effective Date: ____ / ____ / _____

EMPLOYEE RETIREMENT CONTRIBUTIONS

Payroll Pre-Tax Salary Reduction**** _____ % or $_____ Effective Date: ____ / ____ / _____

Payroll After-Tax Salary Reduction****_____ % or $_____ Effective Date: ____ / ____ / _____

******PAYROLL DEDUCTIONS FREQUENCY**

[ ] Monthly (12 paychecks per year) [ ] Twice monthly (24 paychecks per year)
[ ] Bi-Weekly (26 paychecks per year) [ ] Weekly (52 paychecks per year)

Annual Contribution Limits

The IRS allows a maximum contribution on a yearly basis that depends on your salary. The maximum limits can be found on our website at **www.pbucc.org**.

INVESTMENT ALLOCATIONS*

Information about our funds is available online. Allocation of Future Contributions is 5% increments.

		Sustainable Balanced Fund	Bond Fund	Equity Fund	Stable Value Fund	Global Sustainability Index Fund	TAD Fund 2025	TAD Fund 2030	TAD Fund 2035	TAD Fund 2040	TAD Fund 2045	TAD Fund 2050	**Fund percentage must total 100%**
1	Employer Contributions	%	%	%	%	%	%	%	%	%	%	%	Total: _____%
2	Employee TSA and After-Tax Contributions	%	%	%	%	%	%	%	%	%	%	%	Total: _____%

Note for new members, once the pension account is established, you will receive a seven-digit Member ID number included in your enrollment letter. Your Member ID may be used on any correspondence sent to the Pension Boards. It may also be used to access the Member Portal on our website at **www.pbucc.org**.

*If you do not update allocations above, any contributions made on your behalf will be invested in the Target Annuitization Date (TAD) Fund most appropriate to your anticipated retirement timeline based on your age.

BENEFICIARY INFORMATION:

Beneficiary(ies): I hereby designate the following as Primary or Secondary Beneficiary(ies). If more than one is designated, each surviving Beneficiary shall receive the percentage share indicated. **Total proportion of designations must total 100%.** Please note, if you designate a minor as a beneficiary, you are required to have a probate court-appointed guardian to receive and administer the death benefits to the minor. Do not write the name of the guardian on this form. You must submit a complete copy of the Trust. If you do not elect a beneficiary, your Estate will be the primary beneficiary.

1. SSN: _____ Name (last, first, middle initial): _____

Address Line 1: _____ Address Line 2: _____

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

[ ] Domestic [ ] Foreign

Relationship to participant: _____ Date of Birth: ____ / ____ / _____ Gender: [ ] M [ ] F

Annuity: [ ] Primary _____% [ ] Secondary _____ %

2. SSN: _____ Name (last, first, middle initial): _____

Address Line 1: _____Address Line 2: _____

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

[ ] Domestic [ ] Foreign

Relationship to participant: _____ Date of Birth: ____ / ____ / _____ Gender: [ ] M [ ] F

Annuity: [ ] Primary _____% [ ] Secondary _____ %

[ ] Additional Primary and Secondary Beneficiary(ies): Check if applicable, and list information on a separate sheet of paper and attach to this form.

EMPLOYEE (Member) AGREEMENT

[ ] As a member (as defined in the Annuity Plan document), together with my designated Beneficiary or Beneficiaries (as defined in the Annuity Plan document), I acknowledge that the **Annuity Plan document** is available to me on the Pension Boards website (**www.pbucc.org**). I acknowledge that I and my Beneficiary shall, always, be subject to the terms and conditions of the Annuity Plan document, as the same may be amended, modified, or supplemented at the sole discretion of The Pension Boards–United Church of Christ, Inc.

[ ] I understand: (1) my election regarding elective deferrals is irrevocable once the employer withholds the deferrals from my pay; (2) any changes in elective deferrals are effective only for deferrals from pay I received after the plan administrator accepts my change of election. I understand that the amount of such reduction, pursuant to this election, will be withheld from my pay on a pre-tax and/or after-tax basis, as specified above, and will be paid by my employer into my account in the Annuity Plan; and (3) written notice must be given before the effective date of any modification. This election will remain in effective until I revoke complete a new Employee Pre-Tax Retirement Contribution Agreement.

[ ] I have attached a copy of my birth certificate. If I cannot supply a birth certificate, I have attached a copy of my passport or driver's license. **(THIS APPLIES TO FIRST-TIME ANNUITY FUND MEMBERSHIP ENROLLMENTS ONLY.)**

[ ] I have a attached a copy of my Ordination Certificate. If I cannot supply an ordination certificate, then I have attached other documentation such as an official statement from the UCC Association or Conference showing standing.

[ ] As an eligible employee in the Flexible Benefit Plan for UCC Ministries, I understand that I should review the **Highlights of Your Flexible Benefit Plan for UCC Ministries** to understand the benefits available to me, as well as the other rights and obligations which I have under the plan.

[ ] I certify that dependents listed are eligible to enroll in an employer-sponsored health plan. If my status or my dependent's status changes, I agree to notify the Pension Boards immediately.

[ ] I have completed the MetLife Enrollment form for Life Insurance and Disability Income Benefits form.

By completing and submitting this form, I hereby apply for membership in the Annuity Plan for the United Church of Christ, in accordance with its Provisions, Rules and Procedures.

Employee (Member) Signature: _____ Date: ____ / ____ / _____

Witness's Signature (not a beneficiary): _____ Date: ____ / ____ / _____
(Required if establishing Annuity Benefits Plan for the first time. Not required if you already have an annuity account.)

SPOUSAL CONSENT – Not required if you already have an annuity account established. Required for new members only.

Spousal consent is required if the applicant is married and has not designated their spouse as the sole beneficiary. Please note: A notary is also required if the spouse is signing the form.

Spousal Consent:
[ ] I hereby consent to the above beneficiary(ies) designated by my spouse.

Spouse's Signature _____ Date: ____ / ____ / _____

NOTARY (Please note: A notary is only required if the spouse is signing the form.)

Notary's Signature _____ Date: ____ / ____ / _____

Notary's Stamp:

EMPLOYER AGREEMENT

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.

Employers enrolling in Flexible Spending Account Benefits for the **first time only** must visit our website **www.pbucc.org** or complete an **Adoption Resolution for the Flexible Benefit Plan for UCC Ministries.** The agreement and application must include a $100 start-up fee.

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 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.