



**EMPLOYEE INFORMATION**

**MEMBER ID:** \_\_\_\_\_

Name of Member (last, first, middle initial): \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

**Please complete this form if you are changing employers or modifying benefits. This form is required to be signed by you and your employer, and then submitted to the Pension Boards.**

**EMPLOYER INFORMATION**

New Employer

Employer ID:

\_\_\_\_\_

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Email: \_\_\_\_\_

**BENEFIT PLANS**

Did you previously participate in any of the UCC benefits listed below? If there are any benefits that you are adding for the first time, please complete the [Annuity Plan Membership and Other Benefits Form](#).

1. **Health Benefits**  Plan A  Plan B  Plan C  Yes  No  
 Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_
2. **Dental Benefits with Medical**  Dental 2000  Yes  No  
 Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_
3. **Dental Benefit without Medical**  Dental 2000  Yes  No  
 Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_
4. **Flexible Spending Account**  Yes  No  
 Medical Reimbursement Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Medical Amount: \$ \_\_\_\_\_  
 Dependent Care Reimbursement Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Dependent Care Amount: \$ \_\_\_\_\_
5. **Employee Contribution\***  Yes  No  
 Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_
6. **Life Insurance and Disability Income Benefit Plan**  Yes  No  
 Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_
7. **Optional Additional Death Benefit**  Yes  No  
 Coverage Amount  10  20  30  40  50  60  70  80  90  100  
 Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_
8. **Optional Spouse Death Benefit**  Yes  No  
 Coverage Amount  10  25  
 Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_
9. **Optional Child Death Benefit**  Yes  No  
 Coverage Amount  5  10  
 Effective Date \_\_\_\_/\_\_\_\_/\_\_\_\_
10. **Vision Benefits \*\***  Yes  No

Members who are not currently enrolled in the UCC Vision Plan will need to complete the [Vision Enrollment](#) form and return this to the Pension Boards **along with the annual premium**. Contact Member Services for more information.

## STATEMENT OF HEALTH

**MEDICAL PLAN:** Participants may apply for UCC Commercial 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.

**EXCEPTIONS:** The UCC Medicare Advantage Plan with Rx does not require a Statement of Health form.

**LIFE & DISABILITY INSURANCE:** 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.

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## COMPENSATION/SALARY INFORMATION

Salary Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Annual Cash Salary: \$ \_\_\_\_\_

Annual Housing Allowance: \$ \_\_\_\_\_

Annual Cash plus Housing Allowance: \$ \_\_\_\_\_

Average Number of Hours Worked per week: \_\_\_\_\_ [  ] Full Time [  ] Part Time

**Please note: Salary change dates after the 1<sup>st</sup> of the applicable month, will have changes entered on the 1<sup>st</sup> of the following month.**

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## PENSION DUES CONTRIBUTION

**Please note: Effective change dates after the 1<sup>st</sup> of the applicable month, will have changes entered on the 1<sup>st</sup> of the following month.**

Employer Contribution: \_\_\_\_\_ % Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\*Per payroll deduction

Employee Pre-Tax Salary Reduction\*: \_\_\_\_\_ % or \$ \_\_\_\_\_ Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Employee After-Tax Salary Reduction\*: \_\_\_\_\_ % or \$ \_\_\_\_\_ Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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## PAYROLL DEDUCTIONS – EMPLOYEE ELECTIONS

Compensation 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](http://www.pbucc.org).

**INVESTMENT ALLOCATIONS** – This section only should be completed if you are making changes to current allocations.

	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	<b>Fund percentage must total 100%</b>
<b>Allocation of Future Contributions (5% increments)</b>												
1	Employer Contributions	%	%	%	%	%	%	%	%	%	%	Total: _____ %
2	Employee TSA and After-Tax	%	%	%	%	%	%	%	%	%	%	Total: _____ %
<b>Reallocation of Current Balances (1% increments below)</b>												
3	Employer Contributions	%	%	%	%	%	%	%	%	%	%	Total: _____ %
4	Employee TSA and After-Tax	%	%	%	%	%	%	%	%	%	%	Total: _____ %

\*Information about our investment fund options are available online [Investment Program Overview](#).

**EMPLOYEE (Member) AGREEMENT**

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. I understand: (1) my election regarding elective deferrals is irrevocable once the employer withholds the deferrals from my pay; and (2) any changes in elective deferrals is effective only for deferrals from pay I received after the plan administrator accepts my change of election.

I further understand that written notice must be given before the effective date of any modification. This election will remain in effective until I revoke I in writing or until I complete a new Employee Pre-Tax Retirement Contribution Agreement.

Employee (Member) Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

**EMPLOYER AGREEMENT**

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](mailto:info@pbucc.org); by fax: 212.729.2701; or mail to: Pension Boards-UCC, 475 Riverside Drive, Suite 1020, New York, NY 10115.