



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

Pension Boards Benefits Enrollment Form

PERSONAL INFORMATION

Member ID: *(if applicable)* _____ SSN: _____

Member Name: Last: _____ First: _____ Initial: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Gender: M ☐ F ☐ Date of Birth ____ / ____ / ____ Title: Rev. ☐ Dr. ☐

Relationship Status: Single ☐ Married ☐ Date of Marriage: ____ / ____ / ____ Divorced ☐ Widowed ☐

Spouse Name: _____ Spouse Date of Birth: ____ / ____ / ____

Spouse SSN: _____ Gender: M ☐ F ☐

EMPLOYEE INFORMATION

Employer ID: _____ Employer Name: _____

Date of Hire ____ / ____ / ____

Employee Type: ☐ Clergy ☐ Lay

Ordination Date: ____ / ____ / ____

Employment Type: ☐ Full Time ☐ Part Time ☐ Contract

Average Hours Worked Per Week: _____

Self Employed: Y ☐ N ☐

First UCC Employer: Y ☐ N ☐

COMPENSATION/SALARY INFORMATION

Salary information is required if the member will be making employee contributions to their Lifetime Retirement Income Plan

Annual Base Salary: \$ _____

Effective Date: ____ / ____ / ____

Annual Housing Allowance: \$ _____

Annual Base Salary plus Housing Allowance: \$ _____

EMPLOYER CONTRIBUTION TO LIFETIME RETIREMENT INCOME PLAN

Contributions after the 1st of the applicable month will have changes entered on the 1st of the following month.

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

Employer Matching contributions: _____ % up to _____ % (for example 50% up to 6%, i.e., 3%)

EMPLOYEE CONTRIBUTION AND INVESTMENT ALLOCATIONS

You must enroll, update, or change your employee Pre-tax/After-tax contributions, as well as update your investment allocation and beneficiaries by accessing the Fidelity Member Portal.

Please refer to the [Learn More about your Lifetime Retirement Income Plan](#) flyer which will be provided with your enrollment confirmation letter.

☐ I acknowledge my employer will not be able to fund my employee contributions until I have completed my account set-up with Fidelity as instructed in the flyer referenced above.

OPTIONAL BENEFIT PLANS

Information about our optional benefit plans is available online. Visit our website at www.pbucc.org and select the Pension & Benefits option to review plan materials.

I am enrolling in the following optional benefits: **Complete each section for all plans selected.**

- | | |
|---|--|
| ☐ UCC Medical Benefits Plan | ☐ UCC Vision Benefits Plan |
| ☐ UCC Medicare Advantage Plan w/Rx | ☐ UCC Flexible Spending Account (FSA) |
| ☐ UCC Dental Benefits Plan | ☐ UCC Life/Disability Benefits Plan |
-

UCC MEDICAL BENEFITS PLAN

Participants may apply for coverage within 90 days of this UCC employment. If applying after this period, a [Medical Statement of Health](#) Form is required. For questions, contact Member Services at 800.642.6543.

UCC NON-MEDICARE PLAN: ☐ Plan A ☐ Plan B ☐ Plan C Effective Date: ____ / 01 / ____

UCC MEDICARE ADVANTAGE PLAN

☐ UCC Medicare Advantage Plan w/Rx Effective Date: ____ / 01 / ____

- ☐ I acknowledge that I am 65+ and am employed by a UCC employer having less than 20 employees and confirm I have attached the completed [Small Employer Exception](#) form with my application form.
- ☐ I have attached a copy of my Medicare ID card showing enrollment in Medicare Part A and Part B.
- ☐ I acknowledge I am applying for UCC Medicare Advantage Plan coverage for my spouse/partner who is 65+ and I have attached a copy of their Medicare ID card showing enrollment in Medicare Part A and Part B (only required if applying for spouse Medicare coverage).

***Note:** UCC Medicare Advantage Plan applicants who apply for medical benefits for their spouse/partner and/or dependents who are not eligible for Medicare must also choose a non-Medicare plan for their spouse/partner and/or dependent(s):

☐ Plan A ☐ Plan B ☐ Plan C

UCC DENTAL BENEFITS PLAN

[] UCC Dental Benefits Plan

Effective Date / 01 /

UCC VISION BENEFITS PLAN

[] UCC Vision Benefits Plan

Effective Date / 01 /

DEPENDENT INFORMATION FOR INSURANCE

You must complete this section if you are applying for spouse/partner and/or dependent health benefits.

[] 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.

Name of Spouse/Partner	Date of Birth	Gender	SSN	Plan(s) Elected
				☐ Medical ☐ Dental ☐ Vision
My spouse/partner is also a UCC member YES NO			Spouse Member ID (if known)	
Name of Dependent Child(ren)	Date of Birth	Gender	SSN	Plan(s) Elected
1.				☐ Medical ☐ Dental ☐ Vision
			Relation:	
2.				☐ Medical ☐ Dental ☐ Vision
			Relation:	
3.				☐ Medical ☐ Dental ☐ Vision
			Relation:	
4.				☐ Medical ☐ Dental ☐ Vision
			Relation:	

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

UCC FLEXIBLE SPENDING ACCOUNT (FSA)

To enroll in either the Flexible Spending Account (FSA) and/or Dependent Care (DC) Benefit, **you must include the Flexible Benefit Plan Election & Salary Redirection Agreement Form** found [here](#).

[] **UCC FSA Benefits Plan** **Effective Date** / 01 /

If you are eligible to enroll in the FSA and/or DC benefit outside the open enrollment period, the FSA and/or DC benefits will be prorated for the remaining months of the year and the effective date will be the 1st of the month following date of enrollment to allow for payroll deduction.

UCC LIFE INSURANCE AND DISABILITY INCOME BENEFITS PLAN

You must be working 20+ hours per week to be eligible for the UCC Life Insurance/Disability Benefits Plan.

To enroll in the UCC Basic Life Insurance/Disability Plan or to elect UCC Optional/Additional Life Insurance Benefits, **you must include the MetLife Enrollment/Change Form** found [here](#).

[] **UCC Life Insurance/Disability Benefits Plan** **Effective Date:** / 01 /

If you are either:

- (a) applying for coverage outside your initial 90 days of eligibility; or
- (b) electing UCC Optional/Additional Life Insurance Benefits over \$10,000,

You must also include the MetLife Statement of Health Form found [here](#). Coverage begins the 1st of the following month after approval by MetLife

EMPLOYEE (Member) AGREEMENT

- ☐ As a Member (as defined in the Lifetime Retirement Income Plan document), I acknowledge that the Lifetime Retirement Income Plan document is available to me at www.pbucc.org, and I acknowledge that I shall always be subject to the terms and conditions of the Lifetime Retirement Income Plan document, as the same may be amended, modified, or supplemented at the sole discretion of The Pension Boards– United Church of Christ, Inc.

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

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

EMPLOYER INFORMATION AND AGREEMENT

Employer signature is not required for self-pay insurance benefits.

Employer signature is required if the member is enrolling under the employer's account for any benefit offered by the employer.

If you are an **existing employer** adding benefits, please ensure your Adoption Agreement is updated accordingly. No action is needed if it is already current.

- ☐ I acknowledge **employee** contributions for the Lifetime Retirement Income Plan cannot be sent to PBUC for this applicant until they have completed their account set-up with Fidelity. The employee should refer to section **EMPLOYEE CONTRIBUTION AND INVESTMENT ALLOCATIONS** (page 2 of this form) and follow instructions provided in the **Lifetime Retirement Income Plan flyer** to set up their account with Fidelity.
- ☐ I acknowledge that as a representative of the employer, I am responsible for validating the applicant's ordination status (if applicable).

Payroll Frequency:

- | | |
|--|--|
| ☐ Monthly (12 paychecks/year) | ☐ Twice Monthly (24 paychecks/year) |
| ☐ Bi-Weekly (26 paychecks/year) | ☐ Weekly (52 paychecks/year) |

First Pay Date in January: _____

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 ID:** _____

Employer Address: _____ **City:** _____ **State:** _____ **ZIP:** _____

Print Name of Authorized Officer: _____

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

Rev 10-2025