

## Dental Benefits Plan Open Enrollment Application

EMPLOYER ID:			
*If you are an existing member and/o above, and your name in the Persona		count, please provide you	ır Member ID number
UCC Dental Plan is offered to employed in a plan other than the UCC's.	es and retirees who do not o	currently have dental cove	rage, or who have coverage
Coverage is available to individuals w or lay employees who were previousl your Employer must sign the form.			•
PERSONAL INFORMATION	_	_	
SSN: Gend	er: [ ] M [ ] F Date of Bi	rth:/	_ Title: [ ] Rev. [ ] Dr.
Relationship Status: [ ] Single [ ] Ma	ried [ ] Divorced [ ] Widowe	ed [ ] Civil Union [ ] Dom	estic Partner
Name of Member (last, first, middle in	nitial):		
Address:	City	State	ZIP
Cell Phone: () Ho	me Phone: ()	Email:	
SPOUSE / PARTNER INFORMATIO	<b>N</b> (if applicable)		
Name of Spouse / Partner (last, first,	middle initial):		<del></del>
SSN: Date of	Birth:/	_ Date of Marriage:	<i>J</i>
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:/			

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## **DEPENDENT INFORMATION FOR INSURANCE** 1. Name of Dependent (last, first, middle initial): Gender: [ ] M [ ] F SSN: \_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_ Relationship: \_\_\_\_\_ 2. Name of Dependent (last, first, middle initial): \_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_\_ Relationship: \_\_\_\_\_ 3. Name of Dependent (last, first, middle initial): \_\_\_\_\_\_ Gender: [ ] M [ ] F SSN: \_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_ Relationship: \_\_\_\_\_ 4. Name of Dependent (last, first, middle initial): \_\_\_\_\_\_ Gender: [ ] M [ ] F SSN: \_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_/\_\_\_\_ Relationship: \_\_\_\_\_\_ Additional Dependent(s): check if applicable, and list information on a separate sheet of paper and attach to this form. **EMPLOYEE (Member) AGREEMENT** By signing this form, I hereby enroll in the UCC Dental Benefits. If my status or my dependent's status changes, I agree to notify the Pension Boards immediately. Self-Pay Members: Billing Preference (Please choose one): [ ] I agree to have my monthly dental premium deducted from my monthly annuity payment. Your monthly annuity benefit must be large enough to accommodate this deduction. If not, you will receive a monthly bill instead. Minimum threshold to pay out is at least \$50 monthly in annuities. [ ] I agree to accept a monthly ebill notice which will instruct me to login and pay online via www.pbucc.org. **EMPLOYER AGREEMENT** Employer signature is not required for self-pay Dental Benefits. Employer signature is required if employee is eligible for any insurance benefit offered by PBUCC. 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.

Please return this signed and completed form by email to: <a href="mailto:info@pbucc.org">info@pbucc.org</a>; by fax: 212.729.2701; or mail to: Pension Boards-UCC, 475 Riverside Drive, Suite 1020, New York, NY 10115.

Employer ID:

Employer Address:

Employer Name:

Signature of authorized officer:

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\_\_\_\_\_\_City\_\_\_\_\_State ZIP

Date: / /