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

Dental Benefits Plan

Open Enrollment Application

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.

UCC Dental Plan is offered to employees and retirees who do not currently have dental coverage, or who have coverage in a plan other than the UCC's.

Coverage is available to individuals who are currently employed by a UCC church or UCC-related entity, or retired clergy or lay employees who were previously employed full-time by a UCC church or UCC-related entity. If you are employed 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: _____/_____/_____

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: _____/_____/_____

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): _____ Gender: [ ] M [ ] F

SSN: _____ 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.

Participant's Signature _____ Date: _____

EMPLOYER AGREEMENT

Employer signature is not required for self-pay Dental Benefits.

Employer signature is required if employee is eligible for UCC Dental Benefits or any insurance benefit offered by PBUCC.

If you are a new Employer to the Pension Boards, you must complete a Qualified Church-Controlled Organization (QCCO) form and submit it to the Pension Boards at the address listed below or attach the form 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 ID: _____

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.