Pension Boards United Church of Christ

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Life Insurance/Disability Income Enrollment Application

	D 11	· ·	Linoinnent Application			
	Personal II	nformation				
Name (last, first, middle initial)		Social Security Number				
Address (number and street)		City, State, ZIP				
Telephone number (with area code)		E-mail address				
()			@			
Date of birth		Gender				
		Female 🗖 🏻 Male 🕻				
/ /19						
	Spouse's Informa					
Spouse's name (last, first, middle initial)	Spouse's Social Se	curity Number	Spouse's date of birth			
		/ /19				
	Salary Inf	formation				
Annualized Salary Basis (cash plus housing):						
\$						
(If you serve more than one UCC-related employer, please put additional data on a separate sheet.)						
Agreement						
It is agreed between the parties hereto that payments at the annual rate of 1½ % of Salary Basis will be made to the Pension						
Boards by the undersigned on the following basis for Group Life Short-Term and Long-Term Disability Benefits. (check one):						
☐ By the employer at 1½ % of Salary Basis.						
$-0r - \frac{1}{2} \cdot \frac{1}{2} $						
☐ By the member (personal billing) at 1½ % of Salary Basis.						
NI (1	D . 1 1					
Name of employer	Date employed		Employer's telephone number (with area code)			
	,	1	(with area code)			
Address (number and street)	<u> </u>	City State 7ID	J			
Address (number and street)	City, State, ZIP					

(over)

Is this your first UCC employment in which you are working	at least 20 hours per week? Yes 🗖 No 🗖				
If no, please list your last UCC employer below.					
and, product four fact of our fact, or a section.					
NT (1	C'. IC				
Name of employer	City/State				
First date of employment	Last date of employment				
The date of one to fine to	and and or emproyment				
	aployer or did not participate in the UCC Life Insurance and				
Disability Income (LIDI) Benefit Plan during your last eligible employment, you must complete a Statement of Health					
Form.					
I desire to become insured, until further notice, for the UCC I	ife Insurance and Disability Income (LIDI) Benefit Plan as				
described in the booklet, Highlights of Your UCC Life Insuran	, , , , , , , , , , , , , , , , , , , ,				
	cipate, verify that I am a full-time employee working 20 or more				
hours per week. I agree that provisions will be made for the pa	yment of the necessary fees on my behalf.				
Signature	and Date				
Employee signature	Date				
Employee digracture	Duce				
	1 120				
	/ /20				
Employer signature	Date				
	/ /20				

MetLife

Group Term Life Insurance Beneficiary Designation

• This form **MUST** be signed before you return it. See "SECTION IV – Signature" on page 3.

SECTION I - Insured Inforr	nation						
Customer Number				Employer Name/Group Policyholder Name			
First Name	N	Middle Name		Last Name			
Address – Street	(City		State ZIP Code		ZIP Code	
Date of Birth	F	Phone Number		SSN			
SECTION II - Plan Informa	tion.)					
I elect that the beneficiary de indicated below:		hown on this for	m apply only	to the p	olans insu	red by MetLife that	at I have
_				Supplemental/Option	onal Life		
SECTION III - Beneficiary I	nformatio	n					
 You MUST designate at least one be listed in the contingent section The sum of the Primary Beneficia 100%. Dollar amounts, fractions are lifyou need more space for additional sections. 	n. ary percentage and decimals v	es MUST equal 100 9 will not be accepted.	%. The sum of the	e Conting	ent Benefici	ary percentages MUS	T equal
Please complete		•					o page.
A. Individual Beneficial PRIMARY BENEFICIARY - Y beneficiaries predecease you, that First Name	our first choice						ny primary Share:
First Name		wilddie iriitiai	viiddic iiitiai Last ivame			Silare. %	
Address – Street		City			State	ZIP Code	
Relationship to Employee	Social Secur	urity Number Date of Birth			Phone Number		
First Name		Middle Initial	Last Name				Share:
Address – Street		City			State	ZIP Code	,,
Relationship to Employee	Social Secur	curity Number Date of Birth		Phone Number ()			
First Name		Middle Initial		Last Name			Share: %
Address – Street		City		State ZIP Code		ZIP Code	
Relationship to Employee	Social Secur	rity Number	Date of Birth		Phone Nu	mber	

are not living at the time of your de any remaining contingent beneficia	ath. If any cont		•			• • •	
First Name		Middle Initial	Last Name			Share:	
Address – Street		City		State	ZIP Code	/0	
Relationship to Employee	Social Security Number		Date of Birth Phone Number ()		mber		
First Name		Middle Initial	Last Name			Share:	
Address – Street		City		State	ZIP Code		
Relationship to Employee	Social Securit	ty Number	Date of Birth	Phone Nu	mber		
■ B. Living Trust - □ Primary □ Contingent If this form is executed by the insured, it is understood and agreed that if MetLife receives satisfactory proof that the aforesaid trust has been revoked or is not in effect at the insured's death, the beneficiary shall be the insured's Estate, unless otherwise indicated on this form.							
Trust Name			Trust Date	Trustee Pl	none Number	Share: %	
Trustee - First Name		Middle Initial	Last Name				
Trustee Address – Street City		City		State	ZIP Code		
 C. <u>Testamentary Trust Created in the Insured's Will</u> − □ Primary □ Contingent The trust(ee) under any last Will and Testament of mine as shall be admitted to probate. 							
						Share:	
 □ D. <u>Insured's Estate</u> - □ Primary □ Contingent If the Insured's Estate is selected as the Primary Beneficiary, no Contingent Beneficiary may be named. 							
E. Charity/Organization Be sure to name the charity or organization			tingent organization director or a	n employee	of that charity/organ	ization.	
Charity/Organization Name			Phone Number ()			Share:	
Address – Street		City		State	ZIP Code		

SE	CTION IV - Signature				
	Check if you are completing and signing this form as agent for the employee under a valid Power of Attorney. Return a copy of the Power of Attorney with this beneficiary form. The Power of Attorney paperwork is subject to review by MetLife.				
	ereby revoke any previous designations, and I designate the person, pheficiary(ies). I reserve the right to change or revoke this designation at any				
	Insured/Owner Name (Please Print)				
>	Insured/Owner Signature	Date (must be date form was completed)			
Но	w to Submit This Form				
	e employee should provide the completed form to their employer or benefits ords.	administrator. Retain a copy for your			
Please note: You MUST return all pages of this form.					