THE BOARD OF PENSIONS
OF THE PRESBYTERIAN CHURCH (U.S.A.)

# Medical Continuation

## ENROLLMENT OR WAIVER

Use this form to continue medical coverage through the Board of Pensions. If you do not wish to elect medical continuation coverage you must waive coverage by completing Parts One and Three.

## Part One – Personal information

| | | |
|---|---|---|
| Name *(first, middle, last)* | | SSN |
| Address | | |
| City | State | ZIP |
| Phone | Email | |

## Part Two – Enrollment

Complete this section if you are enrolling for continued coverage. If you are enrolling any eligible family members, make sure to include them in the section(s) below. If you are waiving coverage, skip to the next page.

**I am enrolling for medical continuation as a** *(check one)*

- ☐ Member who is no longer eligible (e.g., reduction in hours worked)
- ☐ Retired (under age 65)/terminated member
- ☐ Member whose transitional participation has ended
- ☐ Spouse or former/surviving spouse
- ☐ Former covered child (e.g., reached age 26/surviving child)

**List the full name of all eligible family members to be covered including yourself.** Use a separate sheet if necessary.

| | | |
|---|---|---|
| Name *(first, middle, last)* | | |
| Birth date *(mm/dd/yyyy)* | Relationship | SSN |
| Address *(if different from the member's address)* | | |
| City | State | ZIP |

| | | |
|---|---|---|
| Name *(first, middle, last)* | | |
| Birth date *(mm/dd/yyyy)* | Relationship | SSN |
| Address *(if different from the member's address)* | | |
| City | State | ZIP |

| | | |
|---|---|---|
| Name *(first, middle, last)* | | |
| Birth date *(mm/dd/yyyy)* | Relationship | SSN |
| Address *(if different from the member's address)* | | |
| City | State | ZIP |

**Complete and mail this form along with your initial payment to:**
The Board of Pensions of the Presbyterian Church (U.S.A.) 2000 Market Street, Philadelphia, PA 19103-3298
**Note:** Medical continuation coverage cannot take effect until the Board receives your initial payment.
Questions? Call the Board at 800-773-7752 (800-PRESPLAN) (TTY: 711) or send an email to memberservices@pensions.org

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OF THE PRESBYTERIAN CHURCH (U.S.A.)

# Medical Continuation

## ENROLLMENT OR WAIVER

Use this form to continue medical coverage through the Board of Pensions. If you do not wish to elect medical continuation coverage you must waive coverage by completing Parts One and Three.

### Part Two – Enrollment authorization

- I elect to enroll for medical continuation coverage as described in the Benefits Plan of the Presbyterian Church (U.S.A.).
- I authorize the Board of Pensions to deduct the cost of coverage from my pension benefit check. If I am not receiving a pension benefit or the payment amount does not cover the monthly cost of coverage, I agree to pay the cost of coverage and authorize the Board of Pensions to bill me monthly, in advance, for this coverage.
- I understand that I may only enroll in medical continuation at the same coverage level (PPO, EPO, HDHP) in which I was enrolled at the time of termination of coverage. I also understand that if I am continuing PPO medical coverage, my annual medical deductible and medical out-of-pocket maximum are based not on my effective salary at termination, but on a salary range determined for medical continuation for that year. I understand that if I have already satisfied these limits for the calendar year, my limits will not change. However, if I have not satisfied the medical deductible and/or the medical out-of-pocket maximum, my limit(s) may increase or decrease accordingly.
- I understand that my medical continuation coverage will not take effect until the Board of Pensions receives my initial payment.
- I understand that I may permanently terminate this coverage by sending in written notification. The termination date will be the last day of the month for the requested future termination date or the last day of the month in which the written termination request is received (no retroactive terminations are permitted).

I certify that the information on this form is complete and accurate.

Signature *(required)* Date *(mm/dd/yyyy)*

### Part Three – Waiver

Complete this section if you wish to waive continuation coverage.

Effective date of waiver:

I wish to waive coverage for:

☐ myself

☐ my spouse

If you do not wish to waive coverage, complete page 1 of this form

### Part Three – Waiver authorization

- I/we understand and accept that the waiver of medical continuation coverage will be in effect for the duration of my/our medical continuation eligibility period.
- I/we hereby release the Board of Pensions from any and all liability resulting from relying and acting upon the information supplied on this waiver application.

| | |
|---|---|
| Signature of member/subscriber *(required)* | Date *(mm/dd/yyyy)* |
| Signature of spouse *(if applicable)* | Date *(mm/dd/yyyy)* |

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