Specialized Ministry Registration Form

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

Please print, complete, and mail, fax, or email this form to the Board of Pensions.

Use this to report a specialized ministry service. Please report this change within 60 days of the change.

Teaching elders must provide verification from the presbytery validating the specialized ministry service as an extension of ministry at their initial hire and annually thereafter. The Executive Presbyter or Stated Clerk of the presbytery may validate this specialized ministry by either signing the Presbytery Authorization section of this form or by forwarding written verification to the Board under separate cover.

This form cannot be processed if the presbytery verification has not been received.

Member Information

Name SSN Birth Date *(mm/dd/yyyy)*

Address

City State ZIP

Daytime Phone ( ) Email

Date Ordained Current Presbytery

Eligible Family Members

All documentation for eligible family members must be submitted before enrollment can be completed, if not previously submitted. Documentation is required regardless of the plan(s) in which the eligible family member is enrolled. For example, you must submit documentation (such as a marriage license) for your spouse – even if you are waiving coverage under the Medical Plan for your spouse.

* If the eligible family member is to be added to dental or supplemental death benefits coverage, the member should go to pensions.org to learn about eligibility, coverage, limitations, and costs and to complete and submit the appropriate application form.

Spouse's Name SSN

Birth Date *(mm/dd/yyyy)* Gender ☐ M ☐ F

☐ Check here if your spouse is also enrolled under the Benefits Plan as a result of her/his employment.

☐ I checked the above box and my spouse and I are both ordained teaching elders, called to a shared position at the same church and each of us is employed for fewer than 35 hours per week.

Check benefit(s) for which family member is to be enrolled: ☐ Medical ☐ Dental ☐ Supplemental Death
Is this family member enrolled in Medicare Part A or B? ☐ Yes ☐ No

Address *(if different from the member's address)*

City State ZIP

Please list all children, including all non-custodial children, up to age 26. Include a copy of the birth certificate or legal documentation for each child listed.

☐ **Add** ☐ **Drop**

Child's Name SSN

Birth Date *(mm/dd/yyyy)* Disabled ☐ Yes ☐ No Gender ☐ M ☐ F

Check benefit(s) for which family member is to be enrolled: ☐ Medical ☐ Dental ☐ Supplemental Death
Is this family member enrolled in Medicare Part A or B? ☐ Yes ☐ No Is child a legal ward? ☐ Yes ☐ No

Address *(if different from the member's address)*

City State ZIP

☐ **Add** ☐ **Drop**

Child's Name SSN

Birth Date *(mm/dd/yyyy)* Disabled ☐ Yes ☐ No Gender ☐ M ☐ F

Check benefit(s) for which family member is to be enrolled: ☐ Medical ☐ Dental ☐ Supplemental Death
Is this family member enrolled in Medicare Part A or B? ☐ Yes ☐ No Is child a legal ward? ☐ Yes ☐ No

Address *(if different from the member's address)*

City State ZIP

☐ **Add** ☐ **Drop**

Child's Name SSN

Birth Date *(mm/dd/yyyy)* Disabled ☐ Yes ☐ No Gender ☐ M ☐ F

Check benefit(s) for which family member is to be enrolled: ☐ Medical ☐ Dental ☐ Supplemental Death
Is this family member enrolled in Medicare Part A or B? ☐ Yes ☐ No Is child a legal ward? ☐ Yes ☐ No

Address *(if different from the member's address)*

City State ZIP

☐ **Add** ☐ **Drop**

Child's Name SSN

Birth Date *(mm/dd/yyyy)* Disabled ☐ Yes ☐ No Gender ☐ M ☐ F

Check benefit(s) for which family member is to be enrolled: ☐ Medical ☐ Dental ☐ Supplemental Death

Is this family member enrolled in Medicare Part A or B? ☐ Yes ☐ No Is child a legal ward? ☐ Yes ☐ No

Address *(if different from the member's address)*

City State ZIP

Service Information

Effective date of change reported on this form *(mm/dd/yyyy)*

Church/organization name PIN

Address

City State ZIP

Phone ( ) Fax ( ) Email

Position title

Ordained position code from GA Minutes Book

For plan participation, full time is 35 hours or more per week. Number of scheduled hours per week (excluding overtime):

☐ **Part time/20-34 hours** If checked, write actual hours _____ ☐ **Full time/35 hours or greater**

Primary Benefit Group *(select one):*

☐ Installed pastor ☐ Other teaching elders *(working 20 hours/week or more)* ☐ Other teaching elders *(working less than 20 hours/week)*

☐ Other employees *(working 20 hours/week or more)* ☐ Other employees *(working less than 20 hours/week)*

For other teaching elders and other employees, choose a Benefit Group *(select one):*

☐ Group 1 ☐ Group 2 ☐ Group 3 ☐ Group 4 ☐ Group 5

Annual Salary Information

Please enter annual amounts or zero if not applicable.

1. Cash salary *(including employee contributions to 403(b)(9) plans; tax-sheltered annuity plans; unvouchered book, car, and study allowances; vacation pay and overtime)* 1. $_____
2. Housing allowance, utilities, and furnishings allowances 2. $_____
3. Employing organization contributions to 403(b)(9) plans, tax-sheltered annuity plans, and equity allowances *(matching contributions to the Board's Retirement Savings Plan should not be included)* 3. $_____
4. Bonus *(will be included in the year in which the bonus is paid; dues will be billed on a lump-sum basis)* 4. $_____
5. SECA *(for reimbursement in excess of 50% of the teaching elder's SECA tax obligation)* 5. $_____
6. Other allowances *(including copayment and medical expense reimbursement allowances)* 6. $_____

   Do not include expenses reimbursed through vouchers or Benefits Plan dues.
7. Manse amount *(must be at least 30% of lines 1-6 for members residing in a manse)* 7. $_____
8. **Total Annual Effective Salary *(total of lines 1-7)*** 8. $_____

Certain dues are computed and benefits are determined on this amount (subject to minimums and maximums).

Coverage Elections - *To be completed by employee; see your employer for your costs.*

Medical Coverage

Check one medical coverage option based on the option(s) offered by your employer.

☐ PPO Medical ☐ EPO Medical

Select Medical Coverage Level – *Check one*

☐ Member-only ☐ Member + Spouse ☐ Member + Child(ren) ☐ Member + Family

Retirement and Death and Disability Coverage

☐ Retirement Savings Plan [(403(b)(9)] — To begin contributing to the RSP, see pensions.org for more information and forms and consult your employer.

If offered by your employer, these benefits are 100 percent paid by your employer; you do not need to make an election for these benefits.

☐ Pension ☐ Death & Disability

Optional Programs *(If offered by the employer)*

If the applicant wants to enroll in optional coverage, he or she should visit pensions.org to review additional information (Benefits Overview, booklets, and related information) and to print the appropriate form(s) to apply for supplemental death benefits and/or to enroll in the Retirement Saving Plan.

Dental Plan

Please check one:

☐ Yes, applicant is interested in enrolling. Please send him/her information on the options available and an application for completion. Visit pensions.org for more information on the Dental Plan, including eligibility and coverage options and costs.

☐ No, applicant is not interested in enrolling at this time. He/she understands that he/she will be able to enroll at a later date only if he/she has a qualifying life event or if there is an annual enrollment period. He/she also understands that he/she may have a 12-month limitation on dental services and a 24-month limitation on orthodontia coverage for children.

Authorization - *To be completed by applicant and employer*

Applicant authorization

I confirm that the information provided in this application is true, correct, and complete to the best of my knowledge. In accordance with the Benefits Plan, I agree to furnish any information the Board needs in connection with any medical or dental claim for a family member or me, including information about any other group medical coverage.

Waiver of Medical Coverage *(Please check the appropriate box.)*

I acknowledge that I was given the opportunity to enroll in the Medical Plan coverage under the Benefits Plan of the Presbyterian Church (U.S.A.) ("Plan") offered by my employer. **I waive my right to enroll the following individuals for Medical Plan coverage:**

☐ Myself (not permitted under Pastor's Participation) ☐ My Spouse ☐ My Dependents

I understand that my waiver of coverage means that the individuals designated above will not be enrolled for coverage during any month of the calendar year for which I am enrolling and I will not have the opportunity to change my enrollment elections until the next open enrollment period, unless I become eligible for a special enrollment period before that time due to a change in status recognized by the Plan (for example, I get married or have a child).

I understand that a change in my status as a full-time employee may not be a change in status that allows me to revoke my waiver during this calendar year.

I understand that some employer plans offer medical coverage for spouses that is limited to spouses that are not offered coverage through their own employer. Because my employer is offering coverage to me, which would make me ineligible for coverage under any such plan, I understand that I need to confirm with my spouse's plan that I will be eligible for coverage under that plan before I make my election to decline enrollment for myself in this Plan.

I understand that, to avoid paying an assessment under the Affordable Care Act's individual responsibility rules, I may need to obtain health benefit coverage from another source, such as:

- group health coverage through a spouse or parent's employment,
- a government program, including Medicare, Medicaid, and Tricare, or
- individual health insurance coverage, for example, through a health insurance exchange (often called the Marketplace).

I understand that, despite my waiver, I will not qualify for a subsidy for any coverage that I obtain through the Marketplace during the months when I qualify as an eligible employee because of the coverage that was offered to me under the Plan.

If I am a minister enrolled for Pastor's Participation coverage, I understand that my election to waive Medical Plan coverage for my spouse and/or my dependents will not result in any reduction of Medical Plan dues for my employer.

☐ **I certify that I have had the opportunity to consider this decision and, at my choosing, I have had the opportunity to confer with family members, advisors, and others, including legal counsel. I certify that my election to waive coverage under the Plan is made knowingly and voluntarily.**

I hereby consent to the release of my personal health information and, if applicable, that of my eligible family to the Board's representatives and agents, including, without limitation, Cigna Behavioral Health, OptumRx, Highmark, and their successors and assignees, for the purpose of paying claims and Medical Plan operations.

Applicant's signature ***(required)*** Date *(mm/dd/yyyy)*

Please remember:

- **To ensure prompt processing, complete this form carefully and include all of the appropriate signatures and required documentation. Applications submitted without the appropriate signatures are returned, which may result in delayed coverage.**
- **If you choose to enroll for death benefits, you need to complete the separate Beneficiary Designation form.**

Employer Authorization *(cannot be the applicant)*

On behalf of the employer, I certify that we have confirmed eligibility for plan benefits for this employee as defined by the Benefits Plan of the Presbyterian Church (U.S.A.). I confirm the accuracy of the information concerning benefits selection and agree to pay all required dues to the Board of Pensions by the due date.

Authorized person's name *(print)*

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

Title

Daytime phone ( )

Presbytery Authorization

By signing this form, the authorized representative for the Presbytery confirms that this member is engaged in a validated ministry in accordance with the *Book of Order*.

Name of authorized representative *(please print)*

Official capacity Daytime phone ( )

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

Mail, fax, or email this completed form to: The Board of Pensions of the Presbyterian Church (U.S.A.)
2000 Market Street, Philadelphia, PA 19103-3298
800-773-7752 (800-PRESPLAN) Fax: 215-587-6215 Email: memberservices@pensions.org