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

Member Information

Name SSN

Address

City State ZIP

Phone ( ) Fax ( ) Email

Work Status

When did you become incapable of performing the material duties of your regular occupation because of your condition?

What is the last date you worked: ☐ Full time ☐ Part time # of hours

On what date will your salary relationship terminate?

On what date do you expect to return to work?

How does your disabling condition prevent you from performing the material duties of your regular occupation?

Social Security and Medicare Status

Did you opt out of Social Security as a minister? ☐ Yes ☐ No ☐ N/A

If yes, are you eligible for Social Security benefits from previous employment? ☐ Yes ☐ No

Are you receiving SSDI, SSRI, or SSI benefits? ☐ Yes* ☐ No Date of eligibility _____

* *Please send copy of award letter to the Board.*

Are you enrolled in

Medicare Part A ☐ Yes* ☐ No Date _____
Medicare Part B ☐ Yes* ☐ No Date _____
Medicare Part D ☐ Yes* ☐ No Date _____

Are any of your dependents enrolled in

Medicare Part A ☐ Yes* ☐ No Date _____
Medicare Part B ☐ Yes* ☐ No Date _____
Medicare Part D ☐ Yes* ☐ No Date _____

Are you receiving dialysis treatment?
☐ Yes ☐ No Date of first dialysis treatment_____

Do any of your dependents receive dialysis treatment?
☐ Yes ☐ No Date of first dialysis treatment_____

** Please send a copy of Medicare cards to the Board.*

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

Member's Name

Other Medical Coverage

Do you have medical coverage other than through the Benefits Plan of the PC(USA)? ☐ Yes ☐ No

(If yes, then please complete below.)

Name

Address

Policy #

Subscriber name

Subscriber birth date

Other Benefits

Have you applied for benefits under:	**Applied**			**Determination**	
	Yes	No	Date applied	Eligible	Not Eligible
Social Security Disability	☐	☐		☐	☐
Social Security Retirement	☐	☐		☐	☐
Veteran's Benefits	☐	☐		☐	☐
Workers' Compensation	☐	☐		☐	☐
Motor Vehicle Insurance	☐	☐		☐	☐
Employer's Disability Policy	☐	☐		☐	☐
Other Government Programs	☐	☐		☐	☐
Other Benefits	☐	☐		☐	☐

Have you received any payment as a result of your disability from a third party not listed above? ☐ Yes ☐ No

If yes, please provide copy of the award information.

Have you ever received any disability benefit for a previous condition? ☐ Yes ☐ No

If yes, please describe the disability, the benefit source, the dates of disability and disability payments:

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Member's Name

Do you have long-term care insurance? ☐ Yes ☐ No

Have you applied for vocational rehabilitation services? ☐ Yes ☐ No

If yes, provide the organization name, telephone, contact person and status of application:

Dates:

If you wish to continue the dental coverage in effect before your disability, complete the following.

I understand that the Board will withhold the cost of my dental coverage from my disability check. I would like to continue:

	PPO	DMO
Member	☐	☐
Member + spouse	☐	☐
Member + children	☐	☐
Member + children with orthodontia	☐	☐
Family	☐	☐
Family with orthodontia	☐	☐

Please note:

The only change a member can make to his or her dental coverage during a period of disability is from PPO to DMO or from DMO to PPO. A member is not permitted to add anyone to the coverage during disability.

Authorization

I declare that to the best of my knowledge and belief, the information provided above and the benefits application information I provided in support of my disability benefit application is complete and true. I understand that the Benefits Plan authorizes the Board to suspend or terminate payment of disability benefits if I fail to provide the Board with documentation requested by the Board or its vendor partners to substantiate any earned income, Social Security Disability Insurance or other information.

Member's Signature *(required)* Date *(mm/dd/yyyy)*

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Member's Name

Tax Withholding Election

If you do not return this completed form to the Board of Pensions, federal and state tax may be withheld from your disability payment based on the requirements of the Internal Revenue Service and your state of residency.

Federal

Indicate whether you want federal income tax withheld from your monthly disability payment. To determine your withholding allowances, visit the IRS website (irs.gov/pub/irs-pdf/p15.pdf).

No Federal withholding

☐ **NO**, do not withhold federal income tax from my disability payment. (If selected, go to State section below.)

Request Federal withholding

YES, withhold federal income tax from my disability payment based on the information provided in items 1 through 3 below.

1. Number of allowances *(If you are requesting withholding but have no allowances, enter "0.")* _____
2. Marital status *(check one)* ☐ Single ☐ Married ☐ Married but withholding at higher, single rate
3. Additional amount, if any, you wish to have withheld from your monthly disability payment *(Note: You may not enter an amount here without first entering the number of allowances, including zero, on line 1.)* $ _____

State

If you do not reside in one of the states listed in the two paragraphs below, please go to Member's signature, below. Consult your personal tax professional and/or your state's tax withholding instructions for guidance to complete this form.

- If you reside in ARKANSAS, CALIFORNIA, DELAWARE, GEORGIA, IOWA, KANSAS, MAINE, MICHIGAN, NORTH CAROLINA, OKLAHOMA, OREGON, VERMONT, or VIRGINIA, you may elect to have state income tax withheld regardless of your federal income tax election. State income tax withholding is not required by these states if federal income tax is withheld; however, you must make a clear election. Please make the appropriate election by checking one of the boxes below.
- If you reside in MASSACHUSETTS or NEBRASKA, you must have state income taxes withheld, unless you elected to NOT have federal income tax withheld from your disability payment. If you elect to have federal income tax withheld and you do not make a state income tax election, state income tax withholding will be made based on what is required by your state of residency.

Please indicate your state of residency for tax purposes: _____

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No State withholding

☐ **NO**, do not withhold state income tax from my disability payment.

Request State withholding

YES, withhold state income tax from my disability payment based on the information provided in items 1 through 3 below.

1. Number of allowances (If you are requesting withholding but have no allowances, enter "0.") _____
2. Marital status *(check one)* ☐ Single ☐ Married ☐ Married but withholding at higher, single rate
3. Additional amount, if any, you wish to have withheld from your monthly disability payment *(Note: You may not enter an amount here without first entering the number of allowances, including zero, on line 1.)* $ _____

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

Direct Deposit (Required)

Account Information

Name of Financial Institution

Routing Number *(9-digit number)* Member's Bank Account Number

Account Type: ☐ Checking Account ☐ Savings Account

On behalf of myself, my legal representative, and my executor or administrator, I authorize the electronic deposit of my benefit payment to the account listed above. I agree to repay the Board of Pensions any benefit amount erroneously credited to my account. I authorize the Board of Pensions to offset and recoup from my account any benefits paid or due to me or to my estate, survivors, designated beneficiaries, or heirs at law to recover any amount erroneously credited to my account under this authorization. This agreement shall survive the termination of the direct deposit authorization.

This authorization shall remain in effect until the Board of Pensions receives written notification from me of its termination in such a time and manner as to afford the Board of Pensions and the financial institution named above a reasonable opportunity to act on it.

Member's Signature *(required)* Date *(mm/dd/yyyy)*

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