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

**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 _____

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.*

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:

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)*

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 pension or 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 pension payment. To determine your withholding allowances, visit the IRS website (irs.gov/pub/irs-pdf/p15.pdf) or consult your tax professional.

**Complete the following applicable lines.**

1 Check here if you **do not want any** federal income tax withheld from your pension or disability payment.
☐ *(Do not complete line 2 or 3.)*

2 Total number of allowances and marital status you are claiming for withholding from each **periodic** pension or disability payment. *(You also may designate an additional dollar amount on line 3.)* Enter number of allowances _____

**Marital status**: ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate.

3 Additional amount, if any, you want withheld from each pension or disability payment. *(**Note**: For periodic payments, you cannot enter an amount here without entering the number (including zero) of allowances on line 2.)* $ _____

## State

If you do not reside in one of the states listed in the two paragraphs below, please go to Member's Signature at the end of this form. 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 pension 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: _____

Member's Name

**Complete the following applicable lines.**

1 Check here if you **do not want any** state income tax withheld from your pension or disability payment.
☐ *(Do not complete line 2 or 3.)*

2 Total number of allowances and marital status you are claiming for withholding from each **periodic** pension or disability payment. *(You also may designate an additional dollar amount on line 3.)* Enter number of allowances _____

**Marital status**: ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate.

3 Additional amount, if any, you want withheld from each pension or disability payment. *(**Note**: For periodic payments, you cannot enter an amount here without entering the number (including zero) of allowances on line 2.)* $ _____

**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)*



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

# Disability Benefits Agreement

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

**Applicants for Disability Benefits must sign this statement to acknowledge the terms and conditions of the provisions of the Death and Disability Plan. By signing it, you agree to abide by the Plan's terms and any applicable provisions that the Board of Pensions and the General Assembly of the Presbyterian Church (U.S.A.) subsequently approve for benefits.**

I understand that the Board of Pensions reserves the right to suspend or terminate my disability benefits if I do not observe the Benefits Plan conditions.

I agree to

- provide proof of continuing disability, including but not limited to medical examinations, independent evaluations and supporting documentation, when the Board requests it.
- have my benefits reduced — if I do not participate in Social Security — by the amount of the Social Security Disability Income that I would have been eligible to receive had I participated in Social Security.
- have my benefits reduced by any excess income I may have received by participating in an approved trial work period, partial return to work program, or due to my return to full time work.
- report any salary payments, manse or housing allowance I receive from my employer to the Board's Disability team. I understand that my benefits may be reduced if these payments, together with any earned income I receive, are more than 40 percent of my effective salary on the date the disability began.
- apply for Social Security benefits, including the exhaustion of all appeals, as recommended by the Board.
- report promptly to the Board's Disability team when I become entitled to receive other disability-related compensation, such as Social Security disability or Social Security retirement benefits, workers' compensation, veterans benefits, and other benefits under a government benefit or other disability benefits, as well as any compensation, judgment, or settlement paid by any motor vehicle insurance coverage, and any other payments from a third party as a result of the disability. If appropriate under Article XI of the Benefits Plan, these added benefits could reduce my benefits from the Death and Disability Plan.
- a reduction in my monthly disability benefits, my monthly pension benefits, or other benefits payable by the Benefits Plan on my account, to repay in full all overpayments resulting from retroactive benefits I receive from other programs (Article XI), in consideration of the plan's willingness to pay full benefits while claims from other benefits are pending. If I die before any obligation to the Death and Disability Plan is fully repaid, my heirs, successors, executors, and personal representative shall be bound by this agreement.
- remain under proper and adequate medical care, follow all reasonable medical advice and adhere to the treatment plan developed by my treating provider(s) for my medical condition.
- participate in vocational rehabilitation program(s) as recommended by the Board's medical and vocational counsel.
- report my return to any type of work and provide documentation regarding hours and compensation so that the Board may assess my continued disability and the offset of benefits.

Signature of applicant _____ Date *(mm/dd/yyyy)* _____

Print name _____ SSN _____



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# Authorization to Release Medical Plan Information

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

Under federal law, no medical plan, hospital or physician may release certain protected health information (PHI) for uses other than treatment, payment, or healthcare operations without authorization. This authorization form needs to be completed and signed by a Medical Plan member, spouse, legal guardian, or other legal representative to authorize the Board of Pensions to release PHI.

**Please note that you only need to submit this form if medical information is needed for a Benefits Plan or Board of Pensions program other than the Medical Plan of the Benefits Plan. All sections must be completed.**

## Whose PHI is it? *(Please print information below and check appropriate box.)*

Name _____ Last 4 digits of SSN _____

Name of Legal Guardian/Representative *(if applicable)* _____

Address _____

City _____ State _____ ZIP _____ Phone (  ) _____

☐ Medical Plan member ☐ Spouse ☐ Minor child ☐ Adult child

## Recipient of medical information *(Note: Form cannot be processed if you do not provide recipient's name and address.)*

I authorize the Medical Plan to *(Please check appropriate box and then print recipient's name and address on lines below.)*

☐ Release PHI to a friend, family member or representative

☐ Release PHI to my presbytery representative

☐ Release PHI to the Board of Pensions for non Medical Plan use

☐ Release PHI to my spouse

☐ Other _____

Name _____

Address _____

City _____ State _____ ZIP _____ Phone (  ) _____

## Medical information to be released

A. ☐ the complete Medical Plan record for services rendered on or after the following date:_____/_____/_____

B. ☐ only the following information: *(Specifically describe the information to be released, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.)*

_____

_____

**Important note: Unless the authorization is expressly limited, this authorization grants the plan, physician, hospital, or other healthcare provider/organization the right to use or disclose all personal medical information for the purposes described, including medical information about any diagnosis or treatment for mental health, substance abuse, sexually transmitted diseases (such as HIV), cancer, and/or genetic conditions.**

## Purpose of authorization

☐ to permit the Board of Pensions to review Medical Plan issues with recipient identified in "Recipient of medical information" section above.

☐ other _____

## Duration of authorization

This authorization will expire on the following date:_____/_____/_____or on the occurrence of the following event:

## Right to revoke authorization

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Board of Pensions at the address on the last page of this form.

## Acknowledgment of privacy rights

**I understand that**

- a revocation is not effective to the extent that the parties named in this authorization have relied on the use or disclosure of the protected health information prior to the receipt of the revocation;
- information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law; and
- my health plan(s) may not condition payment, enrollment, or eligibility for Medical Plan benefits (if applicable), on whether I provide authorization for the requested release of medical information.

**I understand that I have the right to**

- refuse to sign this authorization; and/or
- inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).

**I authorize the use of a fax copy or a photocopy of this form.**

Name _____

*(Print name above of Medical Plan member, spouse, adult child, or legal representative.)*

If legal guardian or other legal representative, please describe nature of authority by checking appropriate box below.

☐ Natural/adoptive parent

☐ Guardianship Court Order (Please attach copy unless previously approved by the Board of Pensions.)

☐ Power of Attorney (Please attach copy unless previously approved by the Board of Pensions.)

☐ Other _____

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

*(Signature of Medical Plan member, spouse, adult child, or legal representative)*



Return completed form to: Privacy and Security Officer MS25
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

# Authorization for Use or Disclosure of Protected Health Information

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

Under federal law, no medical plan, hospital or physician may use or disclose certain protected health information (PHI) for uses other than treatment, payment, or healthcare operations without authorization. This authorization form needs to be completed and signed by a Benefits Plan member, spouse, legal guardian, or other legal representative to authorize the release of PHI to the Board of Pensions.

**Please note that you only need to submit this form if medical information is needed for a Benefits Plan or Board of Pensions program other than the Medical Plan of the Benefits Plan. All sections must be completed.**

## Whose PHI is it? *(Please print information below and check appropriate box.)*

Name _____ Last 4 digits of SSN _____

Name of Legal Guardian/Representative *(if applicable)* _____

Address _____

City _____ State _____ ZIP _____ Phone (  ) _____

☐ Benefits Plan Member ☐ Spouse ☐ Minor child ☐ Adult child

## Name of Plan/Provider

Name of health plan, physician, practice, hospital, or other healthcare provider/organization maintaining individual's medical record to be released to the Board of Pensions *(Please check appropriate box and then complete information below.)*

☐ Health Plan ☐ Physician ☐ Hospital ☐ Other Healthcare Provider/Organization

Name _____

Address _____

City _____ State _____ ZIP _____ Phone (  ) _____

## Recipient of medical information

I authorize the person or entity identified in "Name of Plan/Provider" section above to release PHI to the Board of Pensions as specified below:

☐ any department ☐ Death & Disability team ☐ Assistance Programs team

☐ other _____

## Medical information to be used or disclosed

A. ☐ the complete medical record for services rendered on or after the following date:_____/_____/_____

B. ☐ only the following medical information: *(Specifically describe the information to be used or disclosed, including, but not limited to, meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc.)*

**Important note: Unless the authorization is expressly limited, this authorization grants the plan, physician, hospital, or other healthcare provider/organization the right to use or disclose all personal medical information for the purposes described, including medical information about any diagnosis or treatment for mental health, substance abuse, sexually transmitted diseases (such as HIV), cancer, and/or genetic conditions.**

## Purpose of authorization

☐ to permit the Board of Pensions to receive and use medical information from the health plan or healthcare provider identified in "Name of Plan/Provider" section above.

☐ other

## Duration of authorization

This authorization will expire on the following date:_____/_____/_____or on the occurrence of the following event:

## Right to revoke authorization

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the party identified in the "Name of Plan/Provider" section of this form.

## Acknowledgment of privacy rights

**I understand that**

- a revocation is not effective to the extent that the parties named in this authorization have relied on the use or disclosure of the protected health information prior to the receipt of the revocation;
- information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law; and
- my healthcare provider(s) and health plan(s) may not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable), on whether I provide authorization for the requested use or disclosure.

**I understand that I have the right to**

- refuse to sign this authorization; and/or
- inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights).

**I authorize the use of a fax copy or a photocopy of this form.**

Name _____

*(Print name above of Benefits Plan member, spouse, adult child, or legal representative.)*

If legal guardian or other legal representative, please describe nature of authority by checking appropriate box below.

☐ Natural/adoptive parent

☐ Guardianship Court Order (Please attach copy unless previously approved by the Board of Pensions.)

☐ Power of Attorney (Please attach copy unless previously approved by the Board of Pensions.)

☐ Other _____

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

*(Signature of Benefits Plan member, spouse, adult child, or legal representative)*

## Contact Information

- If your Board of Pensions representative directed you to send this form directly to the Board, use the address below.
- If your Board of Pensions representative directed you to send this form to your healthcare provider, please do so and ask them to send it, along with your medical information, to us.
- If you are unsure of where to send this form, please call the Board of Pensions at the number below.



Return 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 or Dependent Authorization To Use and Disclose Personal Employment and Financial Information

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

Upon presentation of the original or a photocopy of this signed authorization, I authorize any representative of The Board of Pensions of the Presbyterian Church (U.S.A.), and its designated agents, to release (by written or oral communication) to:

## Intended Recipient of Information:

*(Type or print name of authorized individual and organization, mailing address, and telephone number)*

Name _____

Address _____

City _____ State ZIP _____

Phone (  ) _____

This release includes any information in possession of the Board of Pensions regarding *(check applicable information)*:

- ☐ my employment status, including my current and former employment status and salary.
- ☐ my benefits coverage under the Benefits Plan of the Presbyterian Church (U.S.A.).
- ☐ my disability plan claim(s) and related information. This information may include, but is not limited to, diagnosis, results of physical and/or psychological and psychiatric examinations, laboratory and diagnostic studies, treatment rendered, my healthcare providers' opinion of my physical and mental condition. This authorization does not apply to Medical Plan information. A HIPAA authorization form is required for the release of said information.
- ☐ address and contact information.
- ☐ all of the above.
- ☐ other _____

☐ I understand that this authorization remains valid until such time as I notify the Board, in writing, that it is revoked.

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

Print name _____ Last 4 digits of SSN _____

Address _____

City _____ State ZIP _____



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