



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

Please complete this form and return it to the Board of Pensions to enroll in the Medical Plan. A full-time seminary student designated by a presbytery as a candidate or an inquirer and not otherwise employed in eligible service may enroll for coverage in the Medical Plan.

To enroll in the Benefits Plan, the Board of Pensions must receive your completed and **Signed** application postmarked during the enrollment periods. **The enrollment is August 1 to September 30** or, if you first enroll at the seminary during the spring semester, 60 days from the date the semester begins. The Board will accept enrollment applications only within these enrollment periods. Please remit the following:

- 1. the first month's payment to activate coverage;**
- 2. written verification from your presbytery that you are an inquirer or candidate for ordination; and**
- 3. written verification from your seminary that you are enrolled as a full-time student.**

Visit pensions.org for dues information.

Applicant Information

Name (first, middle, last)

Birth date (mm/dd/yyyy)

SSN

Male Female Single Married*

Date of relationship (mm/dd/yyyy)

*Include a copy of the official documentation issued by a state or foreign jurisdiction.

Permanent address

City

State

ZIP

Daytime phone ()

Email

Mailing address (if different from permanent address)

City

State

ZIP

Eligible Family Members

All documentation for eligible family members must be submitted before enrollment can be completed.

Spouse's Name*

SSN

Birth Date (mm/dd/yyyy)

Gender M F

* Include a copy of the official documentation issued by a state or a foreign jurisdiction.

Is this family member enrolled in Medicare Part A or B? Yes No

Address (if different from the applicant'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.

Child's name _____ SSN _____

Birth date (mm/dd/yyyy) _____ Disabled Yes No Gender M F

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 applicant's address) _____

City _____ State _____ ZIP _____

Child's name _____ SSN _____

Birth date (mm/dd/yyyy) _____ Disabled Yes No Gender M F

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 applicant's address) _____

City _____ State _____ ZIP _____

Child's name _____ SSN _____

Birth date (mm/dd/yyyy) _____ Disabled Yes No Gender M F

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 applicant's address) _____

City _____ State _____ ZIP _____

Child's name _____ SSN _____

Birth date (mm/dd/yyyy) _____ Disabled Yes No Gender M F

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 applicant's address) _____

City _____ State _____ ZIP _____



Effective Date and Selection of Coverage

The coverage automatically takes effect the first of the month following the Board's receipt of the application. The effective date cannot be retroactive. This completed application must be postmarked within the established enrollment periods.

Plan membership requested effective date:

September 1 October 1 Spring semester New candidate/inquirer Approved on *(mm/dd/yyyy)*

New or transfer student *(mm/dd/yyyy)* Anticipated date of graduation *(mm/dd/yyyy)*

Selection of coverage

Select medical benefits coverage: *(Please check one level.)*

Member-only Member + spouse Member + children Member + family

Authorization

I/We confirm that the information provided in this application is true, correct, and complete to the best of my/our knowledge. My/Our signature(s) certifies and confirms that my spouse and/or children are eligible for plan benefits as defined by the Benefits Plan of the Presbyterian Church (U.S.A.). If this information changes, I will immediately notify The Board of Pensions of the Presbyterian Church (U.S.A.). In accordance with the Benefits Plan, I agree to furnish any information the Board needs in connection with any medical claim for a family member or me, including information about any other group medical coverage.

I/We hereby consent to the release of my personal health information and, if applicable, that of my/our children to the Board's representatives and agents, including without limitation, Cigna, OptumRx, and Highmark, their successors and assignees, for the purpose of paying claims and administering the Medical Plan.

I/We also understand that I/we will be billed for coverage a month in advance and must pay the bill for coverage to continue. If I/we do not pay for two consecutive months, I/we understand that coverage will be terminated without right of reinstatement.

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

Spouse's signature *(if applicable)* _____ Date *(mm/dd/yyyy)* _____