Seminary Student Benefits Plan Membership Application

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

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

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 an inquirer or a candidate and not otherwise employed in eligible service may enroll for coverage in the Medical Plan.

The Board of Pensions must receive your completed and **signed** application postmarked (or emailed of faxed) during the enrollment period for your enrollment to take effect. **The enrollment period is August 15 to September 30, 2017,** or within 60 days of the beginning of your full-time enrollment date.

With your application, the following must be submitted before your enrollment is complete:

1. **the first month's payment to activate coverage;**
2. **written verification from your presbytery that you are an inquirer or a candidate for ordination;**
3. **written verification from your seminary that you are enrolled as a full-time student;**
4. **a copy of all supporting documentation specified below, such as a marriage certificate, birth certificate, or letter of intent or decree for adoption.**

Applicant Information

Name *(first, middle, last)*

Birth date *(mm/dd/yyyy)* SSN

☐ Male ☐ Female ☐ Single ☐ Married* Date of marriage *(mm/dd/yyyy)*

**Include a copy of the official documentation (such as a marriage license) 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

Spouse's Name SSN

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

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 Coverage Elections

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 or received via email or fax within the enrollment period.

Plan membership requested effective date:

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

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

Medical Coverage

(Please check one medical coverage option.)

☐ PPO Medical ☐ EPO Medical

Select Medical Coverage Level

(Please check one.)

☐ Member-only ☐ Member + Spouse ☐ Member + Child(ren) ☐ 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, 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)*

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