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

ENR-005
Rev. 7/16

Affiliated Benefits Program Employer Agreement

When you submit this agreement, **please enclose a copy of your most recent payroll register**, along with the completed Affiliated Benefits Program membership applications. It is required that you include the register in order to process your membership applications. No retroactive enrollments are permitted. Coverage can only start on the first day of the month following the date this form and the membership applications are completed, and provided the Board has received all the necessary paperwork by the 15th of the previous month.

A Employer Information

Name _____ PIN *(if previously assigned)* _____

Address _____

City _____ State _____ ZIP _____

Contact _____ Phone ( ) _____

Email _____ Fax ( ) _____

B Employer Benefit Practices

Effective date of enrollment _____

Your effective date for all future employer benefit practice changes will be January 1. No changes to your benefit practices will be permitted with an earlier effective date.

1. Full-Time Non-Installed Teaching Elder: Waiting Period *(not to exceed 90 days)* _____ Hours Required To Participate_____
   % of Employer Contribution for member_____ % of Contribution Member Pays_____
   % of Employer Contribution for spouse_____ % of Employer Contribution for children_____%
   Coverage Selection: ☐ Medical ☐ Medical & DD % of Employer Contribution for family_____%
2. Part-Time Non-Installed Teaching Elder: Waiting Period *(not to exceed 90 days)* _____ Hours Required To Participate_____
   % of Employer Contribution for member_____ % of Contribution Member Pays_____
   % of Employer Contribution for spouse_____ % of Employer Contribution for children_____%
   Coverage Selection: ☐ Medical ☐ Medical & DD % of Employer Contribution for family_____%
3. Exempt Full-Time Lay Employees: Waiting Period *(not to exceed 90 days)* _____ Hours Required To Participate_____
   % of Employer Contribution for member_____ % of Contribution Member Pays_____
   % of Employer Contribution for spouse_____ % of Employer Contribution for children_____%
   Coverage Selection: ☐ Medical ☐ Medical & DD % of Employer Contribution for family_____%
4. Exempt Part-Time Lay Employees: Waiting Period *(not to exceed 90 days)* _____ Hours Required To Participate _____
   % of Employer Contribution for member_____ % of Contribution Member Pays_____
   % of Employer Contribution for spouse_____ % of Employer Contribution for children_____%
   Coverage Selection: ☐ Medical ☐ Medical & DD % of Employer Contribution for family_____%
5. Non-Exempt Full-Time Lay Employees: Waiting Period *(not to exceed 90 days)* _____ Hours Required To Participate_____
   % of Employer Contribution for member_____ % of Contribution Member Pays_____
   % of Employer Contribution for spouse_____ % of Employer Contribution for children_____%
   Coverage Selection: ☐ Medical ☐ Medical & DD % of Employer Contribution for family_____%
6. Non-Exempt Part-Time Lay Employees: Waiting Period *(not to exceed 90 days)* _____ Hours Required To Participate_____
   % of Employer Contribution for member_____ % of Contribution Member Pays_____
   % of Employer Contribution for spouse_____ % of Employer Contribution for children_____%
   Coverage Selection: ☐ Medical ☐ Medical & DD % of Employer Contribution for family_____%

Dues Contribution and Coverage (Employers must contribute a mandatory 50% of employee dues. No mandatory contributions are required for spouse, children, or family coverage.)

Employees are not permitted to waive medical coverage if the employer remits 100% of the employee dues.

Will any employees not be actively at work on the effective date of enrollment (i.e., Disability Workers' Compensation, etc.)? ☐ Yes ☐ No

If yes, please explain.

Workers' Compensation Insurance Does your organization have Workers' Compensation Insurance? ☐ Yes ☐ No

If no, please explain.

Optional Coverage Selection

Check the optional programs you will offer to employees: ☐ Retirement Savings Plan ☐ Dental ☐ Supplemental Disability ☐ Supplemental Death

Retiree Coverage

Has your organization established formal retiree eligibility requirements for medical coverage? ☐ Yes ☐ No

If yes, please attach a copy of your formal written retiree medical eligibility requirements. If no, retirees requesting medical coverage through the Board of Pensions must meet the eligibility provisions of the Benefits Plan of the Presbyterian Church (U.S.A.).

C Employee Information

Please remember to **provide a payroll register**. **Enrollment applications cannot be processed without a payroll register**; return it with this employer agreement form.

Number of non-mandated employees:	All employees on payroll	Employees on payroll enrolling	Employees on payroll not enrolling due to:	
			Other coverage	Contribution requirement
Full-Time Non-Installed Teaching Elders				
Part-Time Non-Installed Teaching Elders				
Exempt Full-Time Lay				
Exempt Part-Time Lay				
Non-Exempt Full-Time Lay				
Non-Exempt Part-Time Lay				
Totals				

Please list all enrolling employees. For each employee, enclose a completed Affiliated Benefits Program Membership Application (ENR-002) along with a copy of a marriage certificate or other official documentation and copies of birth certificates if you are enrolling a spouse or eligible children. If you need to list more employees, attach a separate sheet of paper.

Employee _____ SSN _____

Employee _____ SSN _____

Employee _____ SSN _____

Employee _____ SSN _____

Employee _____ SSN _____

D Agreement

I agree

- to abide by the Employer Provisions (ABP-105). View at pensions.org;
- to remit employee and employer contributions in a timely manner to the Board of Pensions;
- **to notify the Board of Pensions within 30 days of any changes in service (service terminations must be reported immediately; retroactive enrollments will not be accepted);**
- to notify the Board of Pensions in writing at least 45 days prior to withdrawing all employees or all employees in a particular job classification from the Affiliated Benefits Program, that no employees withdrawn will be eligible for Medical Continuation coverage, and that all members with Medical Continuation or Medicare Supplement coverage will also be withdrawn from the Affiliated Benefits Program as a result of such withdrawal, and
- that if payments for Affiliated Benefits Program coverage are in arrears, the Board of Pensions may terminate coverage for these individuals enrolled in the Affiliated Benefits Program.

I confirm the accuracy of the information concerning benefit selection and confirm that the employing organization agrees to remit dues to the Board of Pensions for the benefits provided. Further, I affirm that I am not aware of any conflicts of interest involving my position and my authorization allowing this employing organization to enroll in the Affiliated Benefits Program. If I am in a position of a conflict, I have reported this to the proper individuals in my employing organization who have determined I remain the appropriate person to sign this form.

Authorized employer representative *(print)* _____

Title _____

Daytime phone ( ) _____ Cell phone ( ) _____

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

Please return this completed form, individual applications, certificates, and other forms to

The Board of Pensions of the Presbyterian Church (U.S.A.)
2000 Market Street, Philadelphia, PA 19103-3298
800-773-7752 (800-PRESPLAN) pensions.org