Life Event Change

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

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

Use this form to report a change in eligible family members covered by the Medical Plan and optional benefits plans (dental and/or supplemental death benefits). Change must be consistent with the qualifying life event and received by the Board of Pensions, along with required documentation, within 60 days of the qualifying life event. If the Board does not receive this form within 60 days of the qualifying event, the employee must wait until the next annual enrollment, generally in the fall, to change medical coverage levels.

Please complete this form fully and legibly; incomplete or illegible forms will be returned and processing will be delayed.

Member Information

Name _____ SSN _____

Is the member's covered partner also enrolled in the Traditional Program as a member? ☐ Yes ☐ No

Reason for Change

Please indicate the reason for adding or dropping eligible family members and the date of the qualifying event (e.g., marriage or birth).

Add

Date of qualifying event _____

- ☐ Birth (include copy of birth certificate)
- ☐ Adoption (include copy of letter of intent or adoption decree)
- ☐ Legal ward (include legal documentation)
- ☐ Marriage (include copy of the official documentation issued by a state or foreign jurisdiction)
- ☐ Loss of qualified or employer-provided coverage (proof of previous coverage is required)

Drop

Date of qualifying event _____

- ☐ Divorce or Dissolution of Marriage (include copy of the divorce or dissolution decree)
- ☐ Waiving medical coverage due to having other qualified health plan or employer-based coverage. By checking this box I certify that the employing organization has the Eligible Family Member Coverage Waiver for this member's eligible family member(s) on file.
- ☐ Other _____

To complete the qualifying life event process, please complete the following pages with eligible family member information.

Eligible Family Members

List each eligible family member for whom the change applies (attach a separate sheet of paper if necessary). Make certain to submit the required documentation. The life event will not be processed without the required documentation.

* If the eligible family member is to be added to dental or supplemental death benefits coverage, the member should go to pensions.org to learn about eligibility, coverage, limitations, and costs.

☐ **Add** ☐ **Drop**

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 member's address)*

City State ZIP

☐ **Add** ☐ **Drop**

Child'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 member's address)*

City State ZIP

☐ **Add** ☐ **Drop**

Child'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 member's address)*

City State ZIP

☐ **Add** ☐ **Drop**

Child'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 member's address)*

City State ZIP

Benefit Elections

Select Medical Coverage Level - Check one

☐ Member-only ☐ Member + spouse ☐ Member + child(ren) ☐ Member + family

If you and the spouse are a Member Couple with Children, will your employing organization be remitting dues for Member + family medical coverage? ☐ Yes ☐ No

Waiver of Eligible Family members

If you are waiving coverage for the employee's eligible family members, you must submit the Eligible Family Member Coverage Waiver form to your employer. Please check below to confirm that you submitted an Eligible Family Member Coverage Waiver to your employer.

☐ **Waiver submitted to Employer**

Optional Benefits

Dental Benefits

You can call the Board at 800-773-7752 (800-PRESPLAN) or visit pensions.org/calculatorsandmodelingtools to learn about available options in your area based on your residential ZIP code.

Coverage Selected

☐ PPO (preferred provider organization)
☐ Passive PPO Plan
☐ DMO (dental maintenance organization)

Coverage Level

☐ Member
☐ Member & spouse
☐ Member & children
☐ Member & family

You must select a DMO provider to access care.

DMO primary office # (member)

DMO primary office # (spouse)

DMO primary office # (children)

☐ **Decline**. I understand that I will only be able to enroll during open enrollment each fall or if there is a qualifying event .

Optional Supplemental Death

Member Coverage

1. Have you used any tobacco products within the last 12 months? *(check one)* ☐ Yes ☐ No

2. I want to *(check one)* ☐ Apply for new coverage ☐ Increase coverage level
   ☐ Decrease coverage level ☐ Discontinue coverage
   ☐ Decline. I understand that I will only be able to enroll during open enrollment each fall or if there is a qualifying event.

3. The new coverage level I choose is *(check one, if applicable)*
   ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $150,000
   ☐ $200,000 ☐ $250,000 ☐ $300,000

Spouse Information *(complete this section if applicable)*

Name SSN ☐ Male ☐ Female

Spouse Coverage *(complete only if applying for coverage)*

1. Have you used any tobacco products within the last 12 months? *(check one)* ☐ Yes ☐ No

2. I want to *(check one)* ☐ Apply for new coverage ☐ Increase coverage level
   ☐ Decrease coverage level ☐ Discontinue coverage
   ☐ Decline. I understand that I will only be able to enroll during open enrollment each fall or if there is a qualifying event.

3. The new coverage level I choose is *(check one, if applicable)*
   ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000

Children's Coverage *(covers all eligible children as defined by the Benefits Plan)*
The coverage level I choose is *(check one, if applicable)*

☐ $5,000 ☐ $10,000 ☐ Decline
☐ Decline. I understand that I will only be able to enroll during open enrollment each fall or if there is a qualifying event.

Supplemental Death Benefits Medical Statement (Member)

The Board of Pensions reserves the right to deny enrollment or a claim for benefits in the Supplemental Death Benefits program if the information provided on the medical statement fails to meet the Board's underwriting criteria or is determined to be false or misleading.

Member Information *(must complete)*

SSN Birth Date *(mm/dd/yy)* Height: feet inches Weight: pounds

Answer all questions and subsections.

1. In the three years immediately preceding this application for initial enrollment or increased coverage in the Supplemental Death Benefits program, have you sought medical advice for, received treatment for, or been told that you have:

a) Cancer, leukemia, Hodgkin's disease, or other associated malignancies? ☐ Yes ☐ No

b) Heart disease, stroke, or other related cardiovascular diseases? ☐ Yes ☐ No

c) Alcoholism or a drug habit? ☐ Yes ☐ No

d) Any disease of the kidney? ☐ Yes ☐ No

e) Any disease of the lung? ☐ Yes ☐ No

f) Any disease of the liver? ☐ Yes ☐ No

g) Any neurological disorder (such as seizures or epilepsy)? ☐ Yes ☐ No

2. Have you ever tested positive for HIV? ☐ Yes ☐ No

If you answered "yes" to any questions in 1 and 2 above, please answer these questions:

What is your exact diagnosis?

When was this diagnosis first made?

What medications do you take regularly for this diagnosis?

What treatment plan(s), if any, have you tried or are you following?

Are there any contributing factors, such as smoking or high blood pressure?

3. In the past six months, except for kidney stones or gallbladder removal, hernia repair, or childbirth, have you:

a. been advised to have a surgical procedure but did not have it performed? ☐ Yes ☐ No

If "yes," please explain the recommended surgical procedures and reasons for not having it performed:

b. been hospitalized or had a surgical procedure performed? ☐ Yes ☐ No

If "yes," please explain:

Name and address of the hospital/facility:

Dates of confinement/procedure:

4. Do you participate in any fitness or wellness programs? ☐ Yes ☐ No

If "yes," at what frequency and duration do you participate?

Supplemental Death Benefits Medical Statement (Spouse)

The Board of Pensions reserves the right to deny enrollment or a claim for benefits in the Supplemental Death Benefits Plan if the information provided on the medical statement fails to meet the Board's underwriting criteria or is determined to be false or misleading.

Spouse Information *(must complete)*

Covered Partner's Height: feet inches Weight: pounds

Answer all questions and subsections.

1. In the three years immediately preceding this application for initial enrollment or increased coverage in the Supplemental Death Benefits Plan, have you sought medical advice for, received treatment for, or been told that you have:

a) Cancer, leukemia, Hodgkin's disease, or other associated malignancies? ☐ Yes ☐ No

b) Heart disease, stroke, or other related cardiovascular diseases? ☐ Yes ☐ No

c) Alcoholism or a drug habit? ☐ Yes ☐ No

d) Any disease of the kidney? ☐ Yes ☐ No

e) Any disease of the lung? ☐ Yes ☐ No

f) Any disease of the liver? ☐ Yes ☐ No

g) Any neurological disorder (such as seizures or epilepsy)? ☐ Yes ☐ No

2. Have you ever tested positive for HIV? ☐ Yes ☐ No

If you answered "yes" to any questions above, please answer these questions:

What is your exact diagnosis?

When was this diagnosis first made?

What medications do you take regularly for this diagnosis?

What treatment plan(s), if any, have you tried or are you following?

Are there any contributing factors, such as smoking or high blood pressure?

3. In the past six months, except for kidney stones or gallbladder removal, hernia repair, or childbirth, have you:

a. been advised to have a surgical procedure but did not have it performed? ☐ Yes ☐ No

If "yes," please explain the recommended surgical procedure(s) and reason(s) for not having it performed:

b. been hospitalized or had a surgical procedure performed? ☐ Yes ☐ No

If "yes," please explain:

Name and address of the hospital/facility:

Dates of confinement/procedure:

4. Do you participate in any fitness or wellness programs? ☐ Yes ☐ No

If "yes," at what frequency and duration do you participate?

Designate beneficiaries to receive the Salary Continuation Benefit (SCB) and/or Supplemental Death Benefits (SDB).

Beneficiary Designation

This designation applies to: ☐ SCB ☐ SDB ☐ Both

You may name any person, institution, or trust as a beneficiary. You must name each beneficiary individually; a designation such as "all my children equally" is unacceptable. Include the name and date of any trust and the trustee's name. You may select primary and secondary beneficiaries.

If any primary beneficiaries predecease you, the benefit is divided proportionately among the surviving primary beneficiaries unless you specifically designate otherwise. For example, if you name your adult children as your primary beneficiaries and one of them predeceases you, the benefit will be distributed to the surviving children. If no proportions are specified, the benefit will be divided equally among the primary beneficiaries.

In the event that a beneficiary designation is found to be incomplete or uncertain at the time of your death, the Board reserves the right to make a final determination on the disbursement of benefits as stated under section 10.1 (SCB) and 16.5 (SDB) of the Benefits Plan.

If none of your primary beneficiaries survives you, then your secondary beneficiaries will receive the benefit in the proportions you specify. If no proportions are specified, the benefit will be divided equally among your secondary beneficiaries.

If you are naming more than one primary and/or secondary beneficiary, please specify the percentage of your benefit each beneficiary should receive. The percent share for primary and secondary beneficiaries should each **total 100 percent (use whole percentages: e.g., 34%, not 33.3%**).

1. Your Primary Beneficiary(ies)

Name the primary beneficiary or beneficiaries to receive any benefits in the event of your death.

Full name *(of person, estate, trust, or other)*	Full SSN *(if person)*	Relationship *(if person)*	% Allocation
Executor's or trustee's name *(if estate or trust)*	Trust date *(if trust)*	Birth date *(of beneficiary)*	
Address *(of person beneficiary, executor, trustee, or other)*	City	State	ZIP

Full name *(of person, estate, trust, or other)*	Full SSN *(if person)*	Relationship *(if person)*	% Allocation
Executor's or trustee's name *(if estate or trust)*	Trust date *(if trust)*	Birth date *(of beneficiary)*	
Address *(of person beneficiary, executor, trustee, or other)*	City	State	ZIP

Total primary beneficiary allocation: 100%

2. Your Secondary Beneficiary(ies)

Your secondary beneficiary or beneficiaries receive payment only if all primary beneficiaries predecease you.

Full name *(of person, estate, trust, or other)*	Full SSN *(if person)*	Relationship *(if person)*	% Allocation
Executor's or trustee's name *(if estate or trust)*	Trust date *(if trust)*	Birth date *(of beneficiary)*	
Address *(of person beneficiary, executor, trustee, or other)*	City	State	ZIP

Full name *(of person, estate, trust, or other)*	Full SSN *(if person)*	Relationship *(if person)*	% Allocation
Executor's or trustee's name *(if estate or trust)*	Trust date *(if trust)*	Birth date *(of beneficiary)*	
Address *(of person beneficiary, executor, trustee, or other)*	City	State	ZIP

Total secondary beneficiary allocation: 100%

Note: If you need additional space to designate beneficiaries, please attach a separate sheet with your name, Social Security number, signature, date, the words "Death Benefits," and information about your additional primary and/or secondary beneficiaries, including the allocation percentage.

Authorization

Use and Disclosure

I declare that to the best of my knowledge and belief, all information provided is complete and true concerning my past and present state of physical and mental health and my medical history. I understand that if my present state of health changes after the date this application is signed but before the effective date of coverage, I must submit an updated Medical Statement to the Board of Pensions for consideration. If I fail to report a condition or to file any required updated Medical Statement, I understand that the Board, upon investigation, may determine that:

a) had such original or updated Medical Statement been filed, any non-guaranteed issue coverage would not have been approved. The Board will deny payment in the amount of the non-guaranteed issue coverage and will refund any dues paid for such coverage.

b) the cause of death is a pre-existing condition that should have been reported to the Board of Pensions on an original or updated Medical Statement. Although coverage – initial or additional – would still have been issued, no payment will be made under such initial or additional coverage because death resulted from a pre-existing condition.

I agree that this document and all its contents shall form a part of my enrollment application for Supplemental Death Benefits. The information may be used to decide if I am eligible for coverage. It may also be sent to any individual or organization that performs service in connection with the coverage for which I have applied. I understand any material misstatement can result in denial of benefits. I understand that an authorized representative or I have the right to receive a copy of this application.

Permission to Obtain Information

I hereby authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, insurance company, consumer credit reporting agency, or employer (present or former), or any other similar person, institution, or organization to provide The Board of Pensions of the Presbyterian Church (U.S.A.) with any and all information, including personal health information and copies of records related to me. I authorize The Board of Pensions of the Presbyterian Church (U.S.A.) to access any medical or disability records on file or available to the Board for Benefits Plan claims purposes. The information requested may include all information available as to diagnosis and treatment with respect to any physical or mental condition.

I certify that the information on this form is complete and accurate.

I understand that my beneficiary designation becomes effective when the Board of Pensions receives and approves this form and remains effective until the Board of Pensions receives and approves a new form. I further understand that in the event of a dispute about the eligible beneficiaries at my death, the determination of the Board of Pensions is final and conclusive. I do hereby, for myself, my beneficiaries, heirs, executors, and administrators, release the Board of Pensions from any and all liability for any and all payments that may be made as a result of and in accordance with this form.

Signature of member *(required)* Date *(dd/mm/yyyy)*

Signature of spouse *(required if applying)* Date *(dd/mm/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