Change in Employment Status or Benefit Group

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 changes in benefit group or scheduled hours for employees who are currently participating in the plan. Please report these changes within 60 days of the change.

Employer and Member Information

Employer Name _____ Pin _____

City _____ State _____ ZIP _____

Effective Date of Change *(mm/dd/yyyy)* _____

Member Name _____ Member SSN _____

Reason(s) for Change *(Select a reason and complete the information below that option)*

☐ **Change in eligibility for benefits**

Primary Benefit Group *(select one)*:

☐ Installed pastor ☐ Other teaching elders *(working 20 hours/week or more)*

☐ Other teaching elders *(working less than 20 hours/week)*

☐ Other employees *(working 20 hours/week or more)* ☐ Other employees *(working less than 20 hours/week)*

For other teaching elders and other employees, choose a Benefit Group *(select one. Your established groups can be found by logging in Benefits Connect and reviewing you current year employer agreement):*

☐ Group 1 ☐ Group 2 ☐ Group 3 ☐ Group 4 ☐ Group 5

☐ **Change in scheduled hours per week**

Enter the number of scheduled hours per week *(excluding overtime)*: _____

☐ **Change in scheduled hours per week resulting in ineligibility for plan benefits**

Enter the number of scheduled hours per week *(excluding overtime)*: _____

If the reported change has an impact on salary or optional benefit elections, please complete the Service and Enrollment Information. If there is no impact to salary or optional benefits, please sign below and return the form.

Employer Authorization *(cannot be the applicant)*

On behalf of the employer, I certify that we have confirmed eligibility for plan benefits for this employee as defined by the Benefits Plan of the Presbyterian Church (U.S.A.). I confirm the accuracy of the information concerning benefits selection and agree to pay all required dues to the Board of Pensions by the due date.

Authorized person's name *(print)* _____

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

Title _____ Daytime phone ( ) _____

Turn over to review Service and Enrollment Information

Service and Enrollment Information

Complete this section only if the reported change has an impact on the member's service or benefit enrollment information.

Service Information

Position Title _____

☐ Teaching elder member, Presbyterian Church (U.S.A.). Date ordained *(mm/dd/yyyy)* _____

☐ Other Employee

Annual Salary Information

Please enter annual amounts or zero if not applicable.

1. Cash salary *(including employee contributions to 403(b)(9) plans; tax-sheltered annuity plans; unvouchered book, car, and study allowances; vacation pay and overtime)* 1. $_____
2. Housing allowance, utilities, and furnishings allowances 2. $_____
3. Employing organization contributions to 403(b)(9) plans, tax-sheltered annuity plans, and equity allowances *(matching contributions to the Board's Retirement Savings Plan should not be included)* 3. $_____
4. Bonus *(will be included in the year in which the bonus is paid; dues will be billed on a lump-sum basis)* 4. $_____
5. SECA *(for reimbursement in excess of 50% of the teaching elder's SECA tax obligation)* 5. $_____
6. Other allowances *(including copayment and medical expense reimbursement allowances)* 6. $_____

   Do not include expenses reimbursed through vouchers or Benefits Plan dues.
7. Manse amount *(must be at least 30% of lines 1-6 for members residing in a manse)* 7. $_____
8. **Total Annual Effective Salary *(total of lines 1-7)*** 8. $_____

Certain dues are computed and benefits are determined on this amount (subject to minimums and maximums).

Coverage Elections - *To be completed by employee; see your employer for your costs.*

Medical Coverage

Check one medical coverage option based on the option(s) offered by your employer.

☐ PPO Medical ☐ EPO Medical

Select Medical Coverage Level – *Check one*

☐ Member-only ☐ Member + Spouse ☐ Member + Child(ren) ☐ Member + Family

Retirement and Death and Disability Coverage

☐ Retirement Savings Plan [(403(b)(9)] — To begin contributing to the RSP, see pensions.org for more information and forms and consult your employer.

If offered by your employer, these benefits are 100 percent paid by your employer; you do not need to make an election for these benefits.

☐ Pension ☐ Death & Disability

Optional Programs *(If offered by the employer)*

If you would like to enroll in optional coverage, Please visit pensions.org to review additional information (Benefits Overview, booklets, and related information) and to print the appropriate form(s) to apply for Supplemental Death benefits.

Dental Plan

Please check one:

☐ Yes, I am interested in enrolling. Please send me information on the options available and an application for completion. Visit pensions.org for more information on the Dental Plan, including eligibility and coverage options and costs.

☐ No, I am not interested in enrolling at this time. I understand that I will be able to enroll at a later date only if I hav a qualifying life event or during annual enrollment period. I also understand that I may have a 12-month limitation on dental services and a 24-month limitation on orthodontia coverage for children.

Eligible Family Members

All documentation for eligible family members must be submitted before enrollment can be completed. Documentation is required regardless of the plan(s) in which the eligible family member is enrolled. For example, you must submit documentation (such as a marriage license) for your spouse – even if you are waiving coverage under the Medical Plan for your spouse.

If the eligible family member is to be enrolled in dental or supplemental death benefits coverage, please visit pensions.org to learn about eligibility, coverage, limitations, and costs and to complete and submit the appropriate application form.

Spouse's Name SSN

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

Check benefit(s) for which family member is to be enrolled: ☐ Medical ☐ Dental ☐ Supplemental Death

Is spouse enrolled in Medicare Part A or B? ☐ Yes ☐ No

Address *(if different from the member'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

Check benefit(s) for which family member is to be enrolled: ☐ Medical ☐ Dental ☐ Supplemental Death

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

Check benefit(s) for which family member is to be enrolled: ☐ Medical ☐ Dental ☐ Supplemental Death

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

Authorization - *To be completed by member and employer*

Member authorization

I confirm that the information provided is true, correct, and complete to the best of my knowledge. In accordance with the Benefits Plan, I agree to furnish any information the Board needs in connection with any medical or dental claim for a family member or me, including information about any other group medical coverage.

Waiver of Medical Coverage *(Please check the appropriate box.)*

I acknowledge that I was given the opportunity to enroll in the Medical Plan coverage under the Benefits Plan of the Presbyterian Church (U.S.A.) ("Plan") offered by my employer. **I waive my right to enroll the following individuals for Medical Plan coverage:**

☐ Myself (not permitted under Pastor's Participation) ☐ My Spouse ☐ My Dependents

I understand that my waiver of coverage means that the individuals designated above will not be enrolled for coverage during any month of the calendar year for which I am enrolling and I will not have the opportunity to change my enrollment elections until the next open enrollment period, unless I become eligible for a special enrollment period before that time due to a change in status recognized by the Plan (for example, I get married or have a child).

I understand that some employer plans offer medical coverage for spouses that is limited to spouses that are not offered coverage through their own employer. Because my employer is offering coverage to me, which would make me ineligible for coverage under any such plan, I understand that I need to confirm with my spouse's plan that I will be eligible for coverage under that plan before I make my election to decline enrollment for myself in this Plan.

I understand that, to avoid paying an assessment under the Affordable Care Act's individual responsibility rules, I may need to obtain health benefit coverage from another source, such as:

- group health coverage through a spouse or parent's employment,
- a government program, including Medicare, Medicaid, and Tricare, or
- Individual health insurance coverage, for example, through a health insurance exchange (often called the Marketplace).

I understand that, despite my waiver, I will not qualify for a subsidy for any coverage that I obtain through the Marketplace during the months when I qualify as an eligible employee because of the coverage that was offered to me under the Plan.

If I am a minister enrolled for Pastor's Participation coverage, I understand that my election to waive Medical Plan coverage for my spouse and/or my dependents will not result in any reduction of Medical Plan dues for my employer.

☐ **I certify that I have had the opportunity to consider this decision and, at my choosing, I have had the opportunity to confer with family members, advisors, and others, including legal counsel. I certify that my election to waive coverage under the Plan is made knowingly and voluntarily.**

I hereby consent to the release of my personal health information and, if applicable, that of my eligible family to the Board's representatives and agents, including, without limitation, Cigna Behavioral Health, OptumRx, Highmark, and their successors and assignees, for the purpose of paying claims and Medical Plan operations.

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

Please remember:

- **To ensure prompt processing, review this form for completeness and make sure all required signatures and documentation are included. Forms submitted without the appropriate signatures will be returned, which may result in delayed coverage.**
- **If you choose to enroll for Supplemental Death benefits, you need to complete an additional form that is located on pensions.org.**
- **If enrolling in Death and Disability or Supplemental Death you will need to complete the Beneficiary Designation form.**

Employer Authorization *(cannot be the applicant)*

On behalf of the employer, I certify that we have confirmed eligibility for plan benefits for this employee as defined by the Benefits Plan of the Presbyterian Church (U.S.A.). I confirm the accuracy of the information concerning benefits selection and agree to pay all required dues to the Board of Pensions by the due date.

Authorized person's name *(print)*

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

Title Daytime phone ( )

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