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

Life Event Change

RETIREES, SURVIVORS & INACTIVE PLAN MEMBERS

Use this form to report life events (such as getting married). 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.

Member information	
Name	Last 4 digits of SSN

Reason for change

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

Add

Date of qualifying life event _____

☐ Birth *(include copy of birth certificate)*

☐ Adoption *(include copy of letter of intent or adoption decree)*

☐ Legal ward *(include legal documentation)*

☐ Eligibility for Medicare

☐ 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 life 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

☐ Other _____

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

Complete and email this form to the Board of Pensions at memberservices@pensions.org.
Questions? Call the Board at 800-PRESPLAN (800-773-7752) (TTY: 711)

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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.

☐ **Add** ☐ **Drop**		
Spouse's name		SSN
Birth date *(mm/dd/yyyy)*		Gender ☐ Female ☐ Male
Is this family member enrolled in Medicare Part A or B? ☐ Yes ☐ No		
Address *(if different from the applicant's address)*		
City	State	ZIP

List all children, up to age 26. Include a copy of the birth certificate or legal documentation for each child listed.

☐ **Add** ☐ **Drop**		
Child's name		SSN
Birth date *(mm/dd/yyyy)*		Gender ☐ Female ☐ Male
Is this family member enrolled in Medicare Part A or B? ☐ Yes ☐ No		
Address *(if different from the applicant's address)*		
City	State	ZIP

☐ **Add** ☐ **Drop**		
Child's name		SSN
Birth date *(mm/dd/yyyy)*		Gender ☐ Female ☐ Male
Is this family member enrolled in Medicare Part A or B? ☐ Yes ☐ No		
Address *(if different from the applicant's address)*		
City	State	ZIP

☐ **Add** ☐ **Drop**		
Child's name		SSN
Birth date *(mm/dd/yyyy)*		Gender ☐ Female ☐ Male
Is this family member enrolled in Medicare Part A or B? ☐ Yes ☐ No		
Address *(if different from the applicant's address)*		
City	State	ZIP

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Medical coverage

☐ Medical continuation ☐ Humana Group Medicare Advantage PPO plan*

Coverage level

☐ Member-only ☐ Spouse-only ☐ Member and spouse

* Each person must have Medicare Part A and B to enroll. A copy of the Social Security Act Medicare Health Insurance card must be included with this enrollment.

Waiving or withdrawing medical coverage

☐ Medical continuation coverage* ☐ Humana Group Medicare Advantage PPO plan**

* The waiver of medical continuation coverage will be in effect for the duration of the member's and/or spouse's medical continuation eligibility period if younger than 65.

** Limited re-enrollment guidelines. For details, see Withdraw from the Humana Group Medicare Advantage PPO plan under Authorization for waiving or withdrawing coverage on page 6. If withdrawing because I/we are enrolling in a different Medicare Advantage plan, supplemental coverage (such as a Medigap plan), or TRICARE, I/we understand that completing this form only withdraws us from the Humana Group Medicare Advantage PPO plan; it does not enroll us in a different Medicare Advantage plan, supplemental coverage (such as a Medigap plan), or TRICARE. To enroll, I/we must contact that organization directly.

Supplemental death coverage

I want to *(check one)* ☐ Decrease coverage level ☐ Discontinue coverage

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

Beneficiary designation

I am *(check one)* ☐ Terminated vested and meet the Rule of 70 ☐ Retired

This designation applies to *(check one)* ☐ Salary continuation benefit ☐ Supplemental death benefit *(if enrolled)* ☐ 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 in 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 percent, not 33.3 percent)**.

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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, 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.

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Authorization for enrollment

If you are enrolling in medical coverage, authorize the section below. If you are waiving or withdrawing coverage, authorize the Waiving or Withdrawing Coverage section on the following page.

I elect to enroll for the medical continuation coverage as described in the Benefits Plan of the Presbyterian Church (U.S.A.).

I elect to enroll for coverage in the Humana Group Medicare Advantage PPO plan.

I authorize the Board of Pensions to deduct the cost of coverage from my pension benefit check. If I am not receiving a pension benefit or the payment amount does not cover the monthly cost of coverage, I agree to pay the dues and authorize the Board of Pensions to bill me monthly, in advance, for this coverage.

I understand that I may permanently terminate this coverage by sending in written notification. The termination date will be the last day of the month for the requested future termination date or the last day of the month in which the written termination request is received (no retroactive terminations will be permitted).

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

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Authorization for waiving or withdrawing coverage

Authorize the section below if you are waiving or withdrawing medical coverage.

Waiver of coverage - Medical continuation

I/We understand and accept that the waiver of medical continuation coverage will be in effect for the duration of my medical continuation eligibility period. I/We also understand that I/we will be able to reapply for medical coverage once I/we are eligible for coverage under the Humana Group Medicare Advantage PPO plan.

I/We hereby release the Board of Pensions from any and all liability resulting from relying and acting upon the information supplied on this waiver application.

Waiver of coverage - Humana Group Medicare Advantage PPO plan

I/We understand and accept that:

- if the Board of Pensions approves this application for waiver of coverage, I will have no medical coverage through the Board during the effective term of this waiver; and
- the Board can reinstate coverage under the Humana Group Medicare Advantage PPO plan for the member and/or spouse only at the time of one of these qualifying events: the death of the member and/or spouse, the involuntary loss of medical coverage, retirement, termination of other employment, or any Annual Enrollment period established by the Board.

I/We hereby release the Board of Pensions from any and all liability resulting from relying and acting upon the information supplied on this waiver application.

Withdraw from the Humana Group Medicare Advantage PPO plan

I authorize the Board of Pensions to end my participation in the Humana Group Medicare Advantage PPO plan.

I/we understand that the Board can reinstate coverage under the Humana Group Medicare Advantage PPO plan for the member and/or spouse only at the time of one of these qualifying events: the death of the member and/or spouse; the involuntary loss of medical coverage; retirement; termination of other employment; or any Annual Enrollment period established by the Board.

I/we also understand that I/we must apply for coverage within 60 days of the qualifying event.

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

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