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

Retiree Medical Grant Application

Prequalification

Before you incur an expense, you may request that the Board predetermine if you qualify. Submit this application with a copy of the itemized, estimated costs. If preapproved, submit your receipt(s) after you receive the itemized services and the Board will reimburse you the allowed amount.

Applicant information

Name		Last 4 digits of SSN
Address		Date of Birth
City	State	ZIP
Phone	Email	

Demographic information *(your response to this section is optional)*

By sharing the information below, you'll help us determine who is accessing the benefits, assistance, and education the Board of Pensions provides members of the Benefits Plan of the Presbyterian Church (U.S.A.). Visit pensions.org to learn more about how we ensure your privacy.

Ethnicity *(check one)* ☐ Hispanic or Latinx ☐ Not Hispanic or Latinx ☐ Prefer not to answer

Race *(check one)* ☐ White ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ American Indian or Alaska Native ☐ Two or more races ☐ Prefer not to answer

Gender identity *(check one)* ☐ Man ☐ Woman ☐ Nonbinary ☐ Self-described ______________________ ☐ Prefer not to answer

Type of service

(check one or both as applicable)

☐ Dental

☐ Hearing aids

Employment history with PC(USA) *(spouses and surviving spouses use member's employment history)*

Only complete if you have fewer than 15 years in the Defined Benefit Pension Plan.

Employer	Years served
Employer	Years served
Employer	Years served
Employer	Years served
Employer	Years served

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

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Grant eligibility

To be eligible for this grant, you must be 65 or older, have an adjusted gross income that is less than $77,760 in 2023, and meet certain medical coverage and Benefits Plan participation criteria.

☐ I AM enrolled in the Medicare Supplement Plan through the Board of Pensions.

☐ I AM NOT enrolled in the Medicare Supplement Plan through the Board of Pensions, but I am enrolled in Medicare Parts A & B and in a Medicare Supplement (Medigap) plan OR a Medicare Advantage plan.

Required documentation

Applications will not be processed without the following information attached.

1. A copy of your most recently filed federal income tax Form 1040.
   — If you do not file a return because your income is below the IRS minimum, you may attach a wage statement.
2. A copy of the receipt(s) for services rendered on or after July 1, 2019, that includes the total amount to be considered for reimbursement through the grant; OR, if you are applying for prequalification, a copy of the itemized estimated costs.

IF YOU ARE NOT ENROLLED in the Medicare Supplement Plan through the Board you must also submit

1. a copy of your Medicare Parts A & B cards, as well as proof you are enrolled in a Medicare Advantage plan or Medicare Supplement (Medigap) plan; and
2. a copy of the explanation of benefits for services rendered, if available.

Applicant authorization

I confirm that the information provided in this application is true, correct, and complete to the best of my knowledge. I understand that if I am approved for this grant, I will not be eligible for another Retiree Medical Grant for three years.

Applicant's signature **Date** *(mm/dd/yyyy)*

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Authorization for Direct Deposit

Complete the Authorization for Direct Deposit form to authorize the electronic deposit of your benefit payment. This form must be received by the Board of Pensions no later than the 10th of the month to be effective the first of the following month.

Your personal information	
Name *(first, middle, last)*	Last 4 digits of SSN

Account information
Name of financial institution
Routing number *(9 digits)*
Your bank account number
Account type: ☐ Checking account ☐ Savings account

Authorization	
On behalf of myself, my legal representative, and my executor or administrator, I authorize the electronic deposit of my benefit and/or Assistance Program grant payment to the account listed above. I agree to repay the Board of Pensions any benefit amount erroneously credited to my account, and I authorize the Board of Pensions to offset from my account and/or any death benefit payable to my estate, survivors, designated beneficiaries, or heirs at law any amount erroneously credited to my account under this authorization. This agreement shall survive the termination of the direct deposit authorization. This authorization shall remain in effect until the Board of Pensions receives written notification from me of its termination in such a time and manner as to afford the Board of Pensions and the financial institution named above a reasonable opportunity to act on it.	
Authorized signature *(required)*	Date *(mm/dd/yyyy)*
If this form is being completed by a legal representative, include the supporting documents, if not previously submitted.	

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