Medical Continuation Enrollment or Waiver

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

If you elect to continue medical coverage, the annual medical deductible and copayment maximums are based on the congregational ministers' median salary for that year. If you have already satisfied these limits for the calendar year, your limits will not change. However, if you have not satisfied the medical deductible and/or the copayment maximum, your limit(s) may increase or decrease accordingly.

Personal information

Name *(first, middle, last)* SSN

Address

City State ZIP

Phone ( ) Email

If you are not the member, complete:

Member's name *(first, middle, last)* Last 4 digits of SSN

Enrollment for coverage *(must sign Authorization Section)*

I want to subscribe for medical continuation coverage as a *(check one):*

☐ Former covered child ☐ Former spouse ☐ Retiring member
☐ Retired member's spouse ☐ Surviving spouse ☐ Terminated member

List full name of all eligible family members to be covered including yourself:

Name *(first, middle, last)* Birth date Relationship SSN

Address *(if different from the member's address)* City State ZIP

Name *(first, middle, last)* Birth date Relationship SSN

Address *(if different from the member's address)* City State ZIP

Name *(first, middle, last)* Birth date Relationship SSN

Address *(if different from the member's address)* City State ZIP

Use a separate sheet if necessary.

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

Application for waiver of coverage *(complete only if you meet the rule of 70 and are waiving coverage)*

I am applying for a waiver of medical continuation coverage under the Benefits Plan of the Presbyterian Church (U.S.A.) and certify that the member and/or spouse's (former spouse's, or surviving spouse's) medical coverage is a qualified health plan. The waiver of medical continuation coverage will be in effect for the duration of the member's medical continuation eligibility period.

Effective date of waiver: _____

I wish to waive medical coverage for myself: ☐ Yes ☐ No

I wish to waive medical coverage for my spouse: ☐ Yes ☐ No

Authorization

Enrollment

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

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 are permitted).

Waiver of coverage

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 the Medicare Supplement Plan provided I/we have had continuous coverage.

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.

_____

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

_____

Signature of spouse *(if applicable)* Date *(mm/dd/yyyy)*

Current and former Board of Pensions employees mail or fax this completed form to
The Board of Pensions of the Presbyterian Church (U.S.A.)
Attn: Human Resources
2000 Market Street, Philadelphia, PA 19103-3298 800-773-7752 (800-PRESPLAN)
Fax: 215-587-6215 email: memberservices@pensions.org

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