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

Medicare Supplement Enrollment, Waiver, or Withdrawal

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

Please review and sign the Authorization section on the last page.

I want to enroll for the Medicare Supplement Plan. I am at least 65 years old or disabled and participate in Medicare Parts A and B.

I want to enroll as a *(check all that apply)*

☐ Retired member ☐ Retired member's spouse ☐ Surviving spouse
☐ Terminated vested member ☐ Former spouse ☐ Disabled dependent

List full name of all eligible family members to be covered including yourself. Use a separate sheet if necessary.

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

Note: Each person must have Medicare Part A & B to enroll. A copy of the Social Security Act Medicare Health Insurance card(s) must be included with this enrollment form.

If you are re-enrolling in the Medicare Supplement Plan and have a waiver or withdrawal on file, please provide documentation for reason for loss of coverage and proof of continuous coverage for each person wishing to re-enroll.

Application for waiver of coverage

Complete only if waiving coverage

I am applying for a waiver of Medicare Supplement Plan of 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.

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

Mail, fax, or email this completed form to: The Board of Pensions of the Presbyterian Church (U.S.A.)

Mail to:	Fax to:	Email to:
2000 Market Street Philadelphia, PA 19103-3298	215-587-6215	memberservices@pensions.org

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

Medicare Supplement Enrollment, Waiver, or Withdrawal

Withdraw from Medicare Supplement

I/We withdraw from the Medicare Supplement Plan. If withdrawing because I/we are enrolling in a Medicare Advantage, Medigap, or TRICARE option, I/we understand that completing this form only withdraws us from the Medicare Supplement Plan; it does not enroll us in a Medicare Advantage, Medigap, or TRICARE option. To enroll, I/we must contact that organization directly.

Coverage withdrawal date* *(mm/dd/yyyy)*:

I wish to withdraw from the Medicare Supplement Plan for myself:: ☐ Yes ☐ No

I wish to withdraw from the Medicare Supplement Plan for my spouse: ☐ Yes ☐ No

*This is the last day you will be covered under the Board's active Medical Plan, Medical Continuation Program, or Medicare Supplement. Because coverage is offered in monthly segments, the end date must be the last day of the month before you join a Medicare Advantage, Medigap, or TRICARE option.

Authorization

Enrollment

I elect to enroll for coverage in the Medicare Supplement Plan of 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 will be permitted).

Waiver of coverage

I/We understand and accept that:

- if the Board of Pensions approves this application for waiver of coverage, the Board will pay no medical benefits during the effective term of this waiver; and
- the Board can reinstate coverage under the Medicare Supplement 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, or termination of other employment.

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

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 Medicare Supplement

I authorize the Board of Pensions to end my participation in the Medicare Supplement Plan. I understand that I cannot re-enroll at a later date *except for the following situations*:

I withdrew to enroll in Medicare Advantage and
- I decide within 12 months that the Medicare Advantage is not meeting my needs;
- I permanently relocate outside the Medicare Advantage Service area;
- Medicare Advantage ceases to offer coverage to Medicare-eligible participants; or
- Medicare Advantage significantly changes my benefits or premiums (subject to review and approval).

I withdrew because I am enrolled in TRICARE and involuntarily lose coverage.

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

Mail, fax, or email this completed form to: The Board of Pensions of the Presbyterian Church (U.S.A.)

Mail to:	**Fax to:**	**Email to:**
2000 Market Street Philadelphia, PA 19103-3298	215-587-6215	memberservices@pensions.org