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

# Supplemental Death Benefits Application

Print or type all information, sign the form, and obtain appropriate authorized signature. Members must also complete and sign a Supplemental Death Benefits Health Statement (Member) (ODB-001) (member does not need to complete if applying for $25,000 or $50,000 coverage level during initial enrollment in the Benefits Plan) and a Beneficiary Designation form (DBN-001). Spouse must also complete and sign a Supplemental Death Benefits Health Statement (Spouse) (ODB-001A).

The Board reserves the right to deny enrollment in the program if the information provided on the Supplemental Death Benefits Health Statement does not meet the Board's underwriting criteria. This coverage is not available to seminary students.

## Member information *(must complete) (if a member couple, see reverse side)*

| Name | | Last 4 digits of SSN | |
|---|---|---|---|
| Phone | Email | | |
| Employer | | PIN | |
| City | | State | ZIP |

**Member coverage**

1. Has the above-named member used any nicotine or nicotine replacement products, including but not limited to tobacco, e-cigarettes, and vape pens, within the last 12 months? *(check one)* ☐ Yes ☐ No
2. I want to *(check one)* ☐ Apply for new coverage ☐ Increase coverage level ☐ Decrease coverage level ☐ Discontinue coverage
3. 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 ☐ $300,000

## Spouse information *(complete this section if applicable)*

| Name | Last 4 digits of SSN | ☐ Female ☐ Male |
|---|---|---|

**Spouse coverage** *(complete only if applying for coverage)*

1. Has the above-named spouse used any nicotine or nicotine replacement products, including but not limited to tobacco, e-cigarettes, and vape pens, within the last 12 months? *(check one)* ☐ Yes ☐ No
2. I want to *(check one)* ☐ Apply for new coverage ☐ Increase coverage level ☐ Decrease coverage level ☐ Discontinue coverage
3. The new coverage level I choose is *(check one, if applicable)* ☐ $25,000 ☐ $50,000 ☐ $75,000 ☐ $100,000

## Children's coverage *(covers all eligible children as defined by the Benefits Plan)*

The coverage level I choose is *(check one, if applicable)* ☐ $10,000 ☐ $20,000

**Complete and email this form to the Board of Pensions at memberservices@pensions.org.**
If you need assistance emailing this form, please contact the Board at 800-773-7752 (800-PRESPLAN).

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## Authorization

I understand that the Board of Pensions will bill my employer for all the costs of the supplemental death benefits coverage, and I consent to my employer deducting these dues from my pay.

The Board will continue to bill for this voluntary optional coverage until I instruct the Board in writing to discontinue coverage. The employer agrees to regularly remit in advance, on the basis of the information on this form, all required dues to the Board of Pensions. I certify that the answer to question(s) on use of nicotine or nicotine replacement products on page 1 of this form is true and correct. I understand that I must complete a Nicotine Use Declaration form (ODB-801) if my status changes.

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

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

| Authorized employer signature *(required)* | Date *(mm/dd/yyyy)* |
|---|---|
| Print name of authorized employer representative | |
| Title or type of authorized employer representative | |

Coverage selected at initial enrollment is effective the same date as the member's participation in the Benefits Plan of the Presbyterian Church (U.S.A.). Coverage selected at the start of a new service or life event change is effective the same date as the requested change. Coverage selected during the annual enrollment period is effective January 1. For coverage to become effective, the member must be actively at work; a spouse or a member on transitional participation must not be confined or disabled. Applications may be submitted during the annual enrollment; the applicant should notify the Board in writing when no longer confined or disabled.

**Member Couples** may enroll for coverage in the Supplemental Death Benefits Plan. Each may enroll as a member or a spouse; neither can enroll as a member and a spouse. Only one member may enroll eligible children.

**Refer to pensions.org for supplemental death benefits coverage rates.**

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