The Pension Boards
United Church of Christ, Inc.
WHERE FAITH AND FINANCE INTERSECT

New Mbr

Lifetime Retirement Income Plan and Other Benefits Membership Form

Use this form to enroll in the Plan and Benefits

MEMBER ID: ☐☐☐☐ - ☐☐☐ SSN: ☐☐☐ - ☐☐ - ☐☐☐☐

PERSONAL INFORMATION

Member Name: Last_____, First_, Initial_____

Address: _____City: _____

State: _____Zip: _____

Home Phone: (____) ____- _____Cell Phone: (____) ____- _____ Email: _____

Gender: M [ ] F [ ] Date of Birth ____/_____/_____ Title: Rev. [ ] Dr. [ ]
MM DD YYYY

Relationship Status: Single [ ] Married [ ] Divorced [ ] Widowed [ ]

SPOUSE / PARTNER INFORMATION (if applicable)

Name of Spouse / Partner (last, first, middle initial): _____

SSN: _____Date of Birth: ____/_____/_____ Date of Marriage: ____/_____/_____
MM DD YYYY MM DD YYYY

[ ] Add spouse / partner as health benefit dependent

EMPLOYEE INFORMATION

Employee Type: [ ] Clergy [ ] Lay UCC Ordination Date: ____/_____/_____

Employment Type: [ ] Full Time [ ] Part Time [ ] Contract Average Hours Worked Per Week: _____

Conference: _____ Self Employed: Y[ ] N [ ]

Date of Hire: ____/_____/_____ First Initial UCC Employer Y [ ] N [ ]
MM DD YYYY

COMPENSATION/SALARY INFORMATION

Annual Base Salary: $ _____ Effective Date: ____/____/_____
MM DD YYYY

Annual Housing Allowance: $ _____

Annual Base Salary plus Housing Allowance: $_____

First Pay Date in January: _____

Compensation Frequency

[ ] Monthly (12 paychecks per year) [ ] Twice monthly (24 paychecks per year)
[ ] Bi-Weekly (26 paychecks per year) [ ] Weekly (52 paychecks per year)

NOTE: Salary change dates after the 1st of the applicable month, will have changes entered on the 1st of the following month.

OPTIONAL BENEFIT PLANS

Information about our additional plans is available online. Visit our website at **www.pbucc.org** and select the Pension & Benefits option.

Please select one or more options in the sections below

[ ] **MEDICAL**** [ ] Plan A [ ] Plan B [ ] Plan C [ ] UCC Medicare Advantage Plan with Rx

Effective Date: ____/____/_____
MM DD YYYY

NOTE: For medical and dental benefits, dependent information is required – see page 3

MEDICARE ADVANTAGE PLAN PARTICIPATION

What plan are you enrolled in?

Medicare Part A [ ] Yes [ ] No Medicare Part B [ ] Yes [ ] No

What plan is your spouse enrolled in?

Medicare Part A [ ] Yes [ ] No Medicare Part B [ ] Yes [ ] No

NOTE: A copy of your or your spouse's Medicare card(s) must be submitted for enrollment into the UCC Medicare Advantage Plan with Rx. The UCC Medicare Advantage Plan with Rx does not require a Statement of Health form.

UCC NON- MEDICARE PLAN STATEMENT OF HEALTH REQUIREMENTS

Participants may apply for coverage within their initial 90-days of UCC employment. A Medical Statement of Health Form is required for applications received past initial eligibility periods. If applicable, please return a completed **Medical Statement of Health form along with this form.

[ ] **DENTAL** [ ] Dental Plan (if Medical coverage is selected)
[ ] Dental Plan Standalone (only if no Medical Coverage is selected)

Effective Date ____/____/_____
MM DD YYYY

[ ] **LIFE INSURANCE AND DISABILITY INCOME BENEFITS****

Effective Date: ____/____/_____
MM DD YYYY

Is this your **initial** UCC employment where you are working at least 20 hours per week?
[ ] Yes [ ] No

[ ] Basic Life Insurance ***

[ ] Optional Additional Life *** [ ] 10 [ ] 20 [ ] 30 [ ] 40 [ ] 50 [ ] 60 [ ] 70 [ ] 80 [ ] 90 [ ] 100

[ ] Optional Spouse Death Benefit *** [ ]10 [ ] 25

[ ] Optional Child Death Benefit *** [ ] 5 [ ] 10

LIFE INSURANCE AND DISABILITY STATEMENT OF HEALTH REQUIREMENTS

A MetLife Statement of Health Form is required for applications received past initial eligibility periods. If applicable, please return a completed **MetLife Statement of Health form along with this form.

*** **For Life Insurance and Disability only:** The completed **Life Insurance and Disability Income (LIDI) MetLife Enrollment Change** needs to be returned along with this form.

[ ] **FLEXIBLE SPENDING ACCOUNT (FSA):** New members can enroll within the first 30 days of their employment. Existing members enroll during the open enrollment period at the end of each calendar year for the following year. The minimum amount you can elect is $100.

Effective Date: ____/____/_____
MM DD YYYY

[ ] I elect Medical Reimbursement

Annual Salary reduction: $_____Medical
Maximum: $3,050

[ ] I elect Dependent Reimbursement

$_____Dependent
Maximum: $5,000

[ ] My health coverage is through my spouse's/partner's UCC Health Plan

Name _____ **Member ID** _____

DEPENDENT INFORMATION FOR INSURANCE – Applicants for Medical and Dental Benefits are required to enter Dependent Information for enrollment.

1. Coverage: [ ] Medical [ ] Dental

Name (last, first, middle initial): _____Relationship to participant: _____

SSN: _____Date of Birth: ___/ ____/ _____Gender: [ ] M [ ] F

2. Coverage: [ ] Medical [ ] Dental

Name (last, first, middle initial): _____Relationship to participant: _____

SSN: _____Date of Birth: ___/ ____/ _____Gender: [ ] M [ ] F

3. Coverage: [ ] Medical [ ] Dental

Name (last, first, middle initial): _____Relationship to participant: _____

SSN: _____Date of Birth: ___/ ____/ _____Gender: [ ] M [ ] F

4. Coverage: [ ] Medical [ ] Dental

Name (last, first, middle initial): _____Relationship to participant: _____

SSN: _____Date of Birth: ___/ ____/ _____Gender: [ ] M [ ] F

[ ] Additional Dependent Information for Insurance: Check if applicable, and list information on a separate sheet of paper and attach to this form.

EMPLOYER PENSION CONTRIBUTION

Please note: Effective change dates after the 1st of the applicable month, will have changes entered on the 1st of the following month.

Employer contributions: _____% or $_____ Effective Date: _____/_____/_____
MM DD YYYY

Employer Matching contributions: _____% up to _____% (for example 50% up to 6%, i.e., 3%)

EMPLOYEE CONTRIBUTION AND INVESTMENT ALLOCATIONS

You can update/change and enroll in Pre-Tax/After-Tax contribution as well as update your investment allocation by accessing the Member Portal.

Please log into www.pbucc.org click on Member Login> Access Fidelity NetBenefits® > Quick Links > Contribution Amount Investments.

To change your investments contributions, go to: www.pbucc.org> Member Login > Access Fidelity NetBenefits® > Quick Links, click on the drop-down menu to select Change Investments then Change Investment Elections.

If you do not indicate your desired allocations, any contributions made on your behalf will be invested in the Target Annuitization Date (TAD) Fund most appropriate to your anticipated retirement timeline based on your age.

You will need to input/update your employee contributions beneficiary(ies) information by logging into NetBenefits®. Log into to your account through www.pbucc.org >Member Login > Access Fidelity NetBenefits®, go to Profile and click on Beneficiaries.

EMPLOYEE (Member) AGREEMENT

[ ] As a Member (as defined in the Lifetime Retirement Income Plan document), I acknowledge that the Lifetime Retirement Income Plan document is available to me at www.pbucc.org, and I acknowledge that I shall always be subject to the terms and conditions of the Lifetime Retirement Income Plan document, as the same may be amended, modified, or supplemented at the sole discretion of The Pension Boards–United Church of Christ, Inc.

[ ] I have a attached a copy of my Ordination Certificate. If I cannot supply an ordination certificate, then I have attached other documentation such as an official statement from the UCC Association or Conference showing standing.

[ ] As an eligible employee in the Flexible Benefit Plan for UCC Ministries, I understand that I should review the **Highlights of Your Flexible Benefit Plan for UCC Ministries** to understand the benefits available to me, as well as the other rights and obligations which I have under the plan.

[ ] I have completed the **MetLife Enrollment form** for Life Insurance and Disability Income Benefits form.

[ ] **Statement of Health:** I understand that applications for UCC Non-Medicare Medical Plan and Life Insurance and Disability Income Plans require Statement of Health forms, if submitted after initial 90-day UCC plan eligibility period.

NOTE: Prior UCC employment will count towards the initial 90-day eligibility period. Applicants that previously opted out of plan eligibility during prior UCC employment may be required to submit a Statement of Health form. Additional Statement of Health criteria includes but is not limited to, lapses in coverage, returning to the plan after disenrolling while actively employed, and adding dependents after eligibility periods.

[ ] I certify that dependents listed are eligible to enroll in an employer-sponsored health plan. If my status or my dependent's status changes, I agree to notify the Pension Boards immediately.

By completing and submitting this form, I hereby apply for membership in the Annuity Plan for the United Church of Christ, in accordance with its Provisions, Rules and Procedures.

Employee (Member) Signature: _____ Date: ____/____/____
MM DD YYYY

EMPLOYER AGREEMENT

Employer signature is not required for self-pay Medical Benefits.

Employer signature is required if employee or dependent(s) is eligible for UCC Medicare Advantage Plan with Rx Plan. Contributions are to be paid by the employer. If the employer employs less than 20 employees, then a **Small Employer Exemption (SEE) form** must be completed and submitted with this application to participate in the UCC Medicare Advantage Plan with Rx Plan.

Employer signature is required if employee is eligible for UCC Medical Benefits for Non-Medicare eligible, or any insurance benefit offered by PBUCC.

Employers enrolling in Flexible Spending Account Benefits for the **first time only** must visit our website **www.pbucc.org** to complete a **Health & Welfare Benefit Adoption Agreement**.

If you are a new Employer to the Pension Boards, you must complete a **Church Plan certification form** and **Qualified Church- Controlled Organization (QCCO) form** and submit it to the Pension Boards at the address listed below or attach the forms to the application for enrollment.

By signing this form, the Employer, by its duly authorized officer or other representative, hereby agrees to the provisions, rules, and procedures with respect to eligibility and contributions as indicated on this application, and in alignment with the Employer Adoption Agreement.

Employer ID # _____

Employer Name: _____

Employer Address: _____City_____State ____ZIP_____

Print Name of Authorized Officer: _____

Signature of Authorized Officer: _____Date: ____/____/_____
MM DD YYYY

Please return this signed and completed form by email to: info@pbucc.org; by fax: 212.729.2701;
or mail to: Pension Boards-UCC, 475 Riverside Drive, Suite 1020, New York, NY 10115.