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

Continuation of Coverage Form

MEMBER ID: _____

PERSONAL INFORMATION

SSN: _____ Date of Birth: _____ Gender: [ ] M [ ] F

Name of Employee (last, first, middle initial): _____Title: _____

Address: _____ City_____ State _____ ZIP_____

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

CONTINUING COVERAGE

I wish to continue the following benefits:

[ ] Medical

[ ] Dental

Effective date: _____

OTHER COVERAGE

Do you have other medical coverage? [ ] Yes [ ] No

If yes, list carrier: _____

SIGNATURE

Under the provisions of the United Church of Christ Health and Dental Benefits Plans, I elect to continue coverage for up to twenty-four (24) months. I acknowledge this coverage will be continued by the payment of the appropriate monthly costs, which will be billed directly to me.

Your premium payment must be attached and returned with this form before enrollment will be processed.

Member Signature _____ Date: _____

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.