



**MEMBER ID:** \_\_\_\_\_

**EMPLOYEE INFORMATION**

Employee Name (last, first, middle initial): \_\_\_\_\_ Title:  Rev.  Dr.

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Email: \_\_\_\_\_

Please complete this form to report new employment status. This form is required to be signed by you and your employer, and then submitted to the Pension Boards.

**EMPLOYER INFORMATION**

New Employer  Employer ID: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Email: \_\_\_\_\_

**CONTINUATION OF INSURANCE BENEFITS**

1. Did you previously have UCC Life Insurance and Disability Income Benefit Plan?  Yes  No

Are you going to continue participating in the UCC Life Insurance and Disability Income Benefit Plan?  Yes  No

Effective: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

2. Are you going to continue Medical Benefits?  Yes  No

Plan A  Plan B  Plan C  HSA

Effective: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

3. Are you going to continue Dental Benefits?  Yes  No

Dental 2000

Effective: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

4. Are you going to continue Vision Benefits?  Yes  No

Vision Benefits Plan

Effective: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**COMPENSATION/SALARY INFORMATION**

Salary Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Base Salary: \$ \_\_\_\_\_

Housing Allowance: \$ \_\_\_\_\_

Total Base plus Housing Allowance: \$ \_\_\_\_\_

Average Number of Hours Worked per week: \_\_\_\_\_ [ ] Full Time [ ] Part Time

**Please note: Any changes to salary will be entered on the first day of the month following the Salary Effective Date.**

**PENSION DUES CONTRIBUTION**

Employer Contribution: \_\_\_\_\_% Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\*Per payroll deduction

Employee Pre-Tax Salary Reduction\*: \_\_\_\_\_% or \$ \_\_\_\_\_ Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Employee After-Tax Salary Reduction\*: \_\_\_\_\_% or \$ \_\_\_\_\_ Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Please note: Any changes to contribution amounts will be entered on the first day of the month following the Effective Date.**

**\*PAYROLL DEDUCTIONS – EMPLOYEE ELECTIONS**

Compensation Frequency

[ ] Monthly (12 paychecks per year) [ ] Twice monthly (24 paychecks per year)

[ ] Bi-Weekly (26 paychecks per year) [ ] Weekly (52 paychecks per year)

**INVESTMENT ALLOCATIONS**

Information about our funds are available online.

	Sustainable Balanced Fund	Bond Fund	Equity Fund	Stable Value Fund	Global Sustainability Index Fund	TAD Fund 2025	TAD Fund 2030	TAD Fund 2035	TAD Fund 2040	TAD Fund 2045	TAD Fund 2050	Fund percentage must total 100%
<b>Allocation of Future Contributions (5% increments)</b>												
1	Employer Contributions	%	%	%	%	%	%	%	%	%	%	Total: _____%
2	Employee TSA and After-Tax	%	%	%	%	%	%	%	%	%	%	Total: _____%
<b>Reallocation of Current Balances (1% increments below)</b>												
3	Employer Contributions	%	%	%	%	%	%	%	%	%	%	Total: _____ %
4	Employee TSA and After-Tax	%	%	%	%	%	%	%	%	%	%	Total: _____ %

**SIGNATURE**

I understand that the amount of such reduction, pursuant to this election, will be withheld from my pay on a pre-tax and/or after-tax basis, as specified above, and will be paid by my employer into my account in the Annuity Plan.

I understand that (1) my election regarding elective deferrals is irrevocable once the employer withholds the deferrals from my pay; and (2) any changes in elective deferrals is effective only for deferrals from pay I received after the plan administrator accepts my change of election.

I further understand that written notice must be given before the effective date of any modification. This election will remain in effective until I revoke it in writing or until I complete a new Employee Pre-Tax Retirement Contribution Agreement.

Member Signature \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

On behalf of the employer, the undersigned hereby agrees to make payments to the Pension Boards for the stated member, based on the effective date and salary data shown.

Signature of treasurer or other authorized officer: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

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