

## Affiliated Benefits Program Membership Application

Please print legibly in ink or type information. For all dates, please use the month, day, and year.

### A Applicant Information

Name \_\_\_\_\_ SSN \_\_\_\_\_

*(First, Middle, Last. This is how your name will appear on all documents from the Board of Pensions.)*

Birth date (mm/dd/yy) \_\_\_\_\_  Male  Female  Single  Married

Date of marriage (mm/dd/yy) \_\_\_\_\_

**Check one:**  Mr.  Mrs.  Miss  Ms.  Rev.  Dr.

*(Ordained minister members must use Dr. or Rev.)*

Have you ever been covered as a member or dependent by the Benefits Plan of the Presbyterian Church (U.S.A.)?  Yes  No

Home address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Daytime phone ( ) \_\_\_\_\_ Cell phone ( ) \_\_\_\_\_

Home phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

Email \_\_\_\_\_ Citizenship (if other than U.S.) \_\_\_\_\_

### B Medical Coverage

Did you have medical coverage under a previous employer/insurance carrier?  Yes  No

My Certificate of Creditable Coverage is included with this membership application.  Yes  No, it will be sent separately.

*(The certificate is provided by the insurance provider to show the dates of previous medical coverage. It helps to determine the time to be credited for any pre-existing condition limitations that may otherwise apply.)*

Are you or your spouse currently enrolled in Medicare?  Applicant  Spouse

**Expenses for treatment of pre-existing conditions will not be covered for the first 12 months. Prior coverage documented by a certificate may reduce the 12-month exclusion. No pre-existing conditions will apply to children under age 19.**

### C Selection of Coverage and Effective Date

Employees may be required to pay for part of the Medical Plan dues; Death and Disability Plan coverage is non-contributory and is the responsibility of the employing organization. If you are enrolling in the Death and Disability Plan, you must complete a Death Benefits Beneficiary Designation form (DBN-001) in order for your application to be processed.

Please check one:

- Medical Plan  Medical, Death and Disability Plan  Death and Disability *(if waiving medical coverage)*  
 Waive coverage due to employee contribution  Waive coverage due to employer group coverage through spouse

#### Medical Plan

Please check one level:  Member coverage  Member and spouse  Member and children  Member and family

Effective date of coverage \_\_\_\_\_

**Note: No retroactive enrollments are permitted. Coverage can only start on the first day of the month following the date the completed application and all other paperwork has been received provided the Board has received all necessary documentation by the 15th of the month.**

## **D** Dependent Information

Spouse's full name \_\_\_\_\_ SSN \_\_\_\_\_ Spouse's birth date \_\_\_\_\_  
(mm/dd/yy)

Check here if your spouse is also a member of the Benefits Plan of the Presbyterian Church (U.S.A.) as a result of her/his employment.

**Please list all dependent children** including all non-custodial dependent children. Include the appropriate status and relationship codes as needed. For additional dependents, attach a separate sheet of paper.

**Status Codes:** **DS:** Permanently disabled age 26 or older and unable to live independently even in a supportive environment. Please include medical verification.

**Relationship Codes:** **S:** Son **SS:** Stepson **D:** Daughter **SD:** Stepdaughter **LW:** Legal Ward

Full name \_\_\_\_\_ SSN \_\_\_\_\_

Birth date \_\_\_\_\_ Gender \_\_\_\_\_ Status \_\_\_\_\_ Relationship \_\_\_\_\_ % Support \_\_\_\_\_  
(mm/dd/yy)

Full name \_\_\_\_\_ SSN \_\_\_\_\_

Birth date \_\_\_\_\_ Gender \_\_\_\_\_ Status \_\_\_\_\_ Relationship \_\_\_\_\_ % Support \_\_\_\_\_  
(mm/dd/yy)

Full name \_\_\_\_\_ SSN \_\_\_\_\_

Birth date \_\_\_\_\_ Gender \_\_\_\_\_ Status \_\_\_\_\_ Relationship \_\_\_\_\_ % Support \_\_\_\_\_  
(mm/dd/yy)

### **Other Medical Coverage**

If you, your spouse, or dependents are covered under any other group medical plan, including coverage for retirees, complete the following:  
(For additional information, please attach a separate sheet of paper.)

Coverage in the name of \_\_\_\_\_ Relationship \_\_\_\_\_

Employer name \_\_\_\_\_ Employer phone ( ) \_\_\_\_\_

Employer address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance carrier \_\_\_\_\_ Group # \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Policy or ID# \_\_\_\_\_ Effective date \_\_\_\_\_

Policy covers:  Applicant  Spouse  Children

Type of benefits \_\_\_\_\_ End date of coverage \_\_\_\_\_  
(for example, medical, dental, prescription) (if applicable)

## **E** Service Information

Church/Organization name \_\_\_\_\_ PIN \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Date employment began \_\_\_\_\_ Fax ( ) \_\_\_\_\_

This section is to be completed by *your employer*. Employer: Please complete all sections applicable to this employee.

## **F** For Ministers and Commissioned Lay Pastors

Position title \_\_\_\_\_ Position code \_\_\_\_\_

Please use the codes in the Authorized Ecclesiastical Occupation Designations in the General Assembly minutes.

Some frequently used codes are:

**105** Interim Pastor or Associate

**106** Stated Supply

**107** Commissioned Lay Pastor

**108** Temporary Supply

**791** Specialized Ministry

(Use 791 only if the specific Specialized Ministry position/title is not in the GA minutes)

### Please check one:

Minister member, Presbyterian Church (U.S.A.). Date ordained (mm/dd/yyyy) \_\_\_\_\_

Minister of another denomination. Please identify denomination \_\_\_\_\_

Date received into PC(USA) \_\_\_\_\_ (please attach Presbytery verification)

### Annual Salary Information

Salary information determines Medical Plan deductible and copayment maximums.

Number of hours worked/week \_\_\_\_\_ Salary Effective Date \_\_\_\_\_

Please enter annual amounts or zero if not applicable.

1. Cash salary (including employee contributions to 403(b)(9) plans; tax-sheltered annuity plans; unvouchered book, car, and study allowances; vacation pay and overtime) \$ \_\_\_\_\_
2. Housing allowance, utilities, and furnishings allowances \$ \_\_\_\_\_
3. Employing organization contributions to 403(b)(9) plans, tax-sheltered annuity plans, and equity allowances (Effective 1/1/08, matching contributions to the Board's Retirement Savings Plan should not be included.) \$ \_\_\_\_\_
4. Bonus (will be included for the current year only; if continuing, you will need to report annually) \$ \_\_\_\_\_  
Year in which bonus is paid \_\_\_\_\_
5. SECA (For reimbursement in excess of 50% of the minister's SECA tax obligation) \$ \_\_\_\_\_
6. Other allowances (including copayment, medical) \$ \_\_\_\_\_  
Do not include expenses reimbursed through vouchers.
7. Manse amount (must be at least 30% of Lines 1-6 for members residing in a manse) \$ \_\_\_\_\_
8. **Total Annual Effective Salary** (total of lines 1-7) \$ \_\_\_\_\_

### Dues are computed and benefits are determined on this amount (subject to minimums and maximums).

Effective Salary is any compensation a member receives during a plan year from an employing organization. For more information, see *Understanding Effective Salary* booklet available on Pensions.org.

You may use the Total Effective Salary Calculator and the Dues Calculator to determine the impact on dues.

## **G** For Lay Employees

Position title \_\_\_\_\_ Position code \_\_\_\_\_ **788**

Classification (Check one):

Exempt\* lay employee

Non-exempt\* lay employee

\*Visit the Department of Labor Web site at <http://www.dol.gov> for classification information.

### Salary Information

Salary information determines Medical Plan deductible and copayment maximums.

Number of hours worked/week \_\_\_\_\_ Salary Effective Date \_\_\_\_\_

Annual salary \_\_\_\_\_ \$ \_\_\_\_\_

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**H Applicant**

I confirm that the information provided in this application is true, correct, and complete to the best of my knowledge. In accordance with the Benefits Plan, I agree to furnish any information the Board needs in connection with any medical or dental claim for a family member or me, including information about any other group medical coverage.

Applicant signature *(required)*

Date

*(mm/dd/yy)*

**Employing Organization**

**On behalf of the employing organization, I certify that we have confirmed eligibility for plan benefits for the spouse and the children as defined by the Benefits Plan of the Presbyterian Church (U.S.A.). Further, I affirm that I am not aware of any conflicts of interest involving my position and my authorizing signature allowing this individual (and dependents if applicable) to enroll in the Affiliated Benefits Program. If I am aware of a conflict, I have reported this to the proper individuals in my employing organization who have determined I remain the appropriate person to sign this form.**

**I confirm the accuracy of the information concerning benefit selection and confirm that the employing organization agrees to remit dues to the Board of Pensions for the benefits provided.**

Authorized employer representative *(print)*

*(cannot be the same as the member)*

Title

Daytime phone (      )

Signature *(required)*

Date

*(mm/dd/yy)*

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**Please mail or FAX this completed form to:**  
The Board of Pensions of the Presbyterian Church (U.S.A.)  
2000 Market Street, Philadelphia, PA 19103-3298  
800-773-7752 (800-PRESPLAN) FAX: 215-587-6215  
Pensions.org