The Board of Pensions
of the Presbyterian Church (U.S.A.)

ENR-004
Rev. 8/11

Affiliated Benefits Program Medical Continuation Subscription or Waiver

Please print legibly or type. Use Section A, B, and C of this form to subscribe to coverage.

A Subscriber Information

Name ____________________ SSN ____________________

Address *(if P.O. Box, include street address)* ____________________

City ____________________ State ________ ZIP ________

If new address, give effective date ____________________

Day time phone (   ) ____________ Cell phone (   ) ____________ Primary Email *(optional)* ____________

If you are not the member, please list the

Member's Name ____________________ SSN ____________________

B Subscription

I want to subscribe for Medical Continuation coverage as a *(check one)*:

☐ Member retiring before age 65*
☐ Spouse
☐ Surviving spouse
☐ Divorced spouse
☐ Terminated (inactive) member
☐ Child covered under medical child support
☐ Child covered under medical child support
☐ Eligible child
☐ Permanently disabled dependent age 26 or older and unable to live independently even in a supportive environment (medical verification will be requested)

Please list everyone you want to enroll for coverage, including yourself. Use a separate sheet if necessary.

Name	Birth Date	Relationship	SSN

*Must meet the Rule of 70 - see MED-101 on Pensions.org.

C Subscription Information

You will be invoiced for your subscription if you receive no benefit payment. You must include payment with this form to activate eligibility. Please call 800-773-7752 (800-PRESPLAN) for current subscription costs.

☐ I wish to have deductions made from my pension check for the full cost of this coverage.

☐ I have enclosed a check to pay for the cost of this coverage through the current month plus one month in advance. *If you wish to have future monthly payments deducted from your bank account via BoardLink®*, visit Pensions.org/boardlink or call 800-773-7752 (800-PRESPLAN) for more information.

I elect to subscribe for the Medical Continuation Program as described in the Benefits Plan of the Presbyterian Church (U.S.A.) (Article XIII, Section 13.15 or Article XIV, Section 14.1). I understand the Board of Pensions must receive this form and my initial payment in order to continue medical coverage.

I authorize the Board of Pensions to bill me monthly, in advance, for this coverage. I understand that I must pay the subscription charges in full through the current month plus one month in advance before coverage can begin. I also understand that I may permanently terminate this subscription at any time by sending advance written notice to the Board of Pensions; if I fail to pay any subscription charge within 30 days of its due date, coverage is permanently terminated.

Signature of member ______________________ Date __________

Signature of subscriber *(if other than member)* ______________________ Date __________

D Application and Authorization for Waiver of Coverage *(Complete only if waiving coverage. Must meet the Rule of 70.)*

I am applying for a waiver of Medical Continuation coverage under the Benefits Plan of the Presbyterian Church (U.S.A.) as the member and/or spouse of the member listed, the divorced spouse, or the surviving spouse. I also certify that the member and/or spouse's, divorced spouse's, or surviving spouse's employer(s) is/are providing group medical coverage. I am attaching **a copy of the member and/or spouse's medical benefits identification card(s)** from the other employer(s).

Name of member's employer ______________________ Name of spouse's employer ______________________

☐ I wish to waive only my coverage now *(member or former spouse must sign below)*

☐ We wish to waive only my spouse's coverage now *(both member and spouse must sign below)*

☐ We both wish to waive coverage now *(both member and spouse must sign below)*

I/we understand and accept that:

- If the Board of Pensions approves this application, the Board will pay no medical benefits whatsoever for the above-named member and/or spouse during the effective term of this waiver.
- The Board can reinstate Medical Continuation coverage for the member and/or spouse or former spouse only at the time of one of these qualifying events: the death of the member and/or spouse, the involuntary loss of medical coverage, retirement, or termination of other employment.

We also understand that we must apply for coverage within 90 days of the qualifying event. If there is a gap in medical coverage of 63 days or more, pre-existing conditions may not be covered.

I/we hereby release the Board of Pensions from any and all liability resulting from relying and acting upon the information supplied on this waiver application.

Signature of member/subscriber *(required)* ______________________ Date *(mm/dd/yyyy)* __________

Signature of spouse *(required)* ______________________ Date *(mm/dd/yyyy)* __________

Please send the completed application 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)

For internal use only: CKD