

Affiliated Benefits Program Employer Agreement

When you submit this agreement, **please enclose a copy of your most recent payroll register**, along with the completed Affiliated Benefits Program membership applications. It is required that you include the register in order to process your membership applications. No retroactive enrollments are permitted. Coverage can only start on the first day of the month following the date this form and the membership applications are completed, and provided the Board has received all the necessary paperwork by the 15th of the previous month.

A Employer Information

Name _____ PIN (if previously assigned) _____

Address _____

City _____ State _____ Zip _____

Contact _____ Phone () _____

Email _____ Fax () _____

B Employer Benefit Practices

Effective date of enrollment _____

1. Non Installed Ministers: Waiting Period (not to exceed one year) _____ Hours Required To Participate _____
 % of Employer Contribution for member _____ % of Contribution Member Pays _____
 % of Employer Contribution for Spouse _____ % of Employer Contribution for children _____ %
 Coverage Selection: Medical Medical & DD Death and Disability Only*

2. Exempt Full-time Lay Employees: Waiting Period (not to exceed one year) _____ Hours Required To Participate _____
 % of Employer Contribution for member _____ % of Contribution Member Pays _____
 % of Employer Contribution for Spouse _____ % of Employer Contribution for children _____ %
 Coverage Selection: Medical Medical & DD Death and Disability Only*

3. Exempt Part-Time Lay Employees: Waiting Period (not to exceed one year) _____ Hours Required To Participate _____
 % of Employer Contribution for member _____ % of Contribution Member Pays _____
 % of Employer Contribution for Spouse _____ % of Employer Contribution for children _____ %
 Coverage Selection: Medical Medical & DD Death and Disability Only*

4. Non-Exempt Full-time Lay Employees: Waiting Period (not to exceed one year) _____ Hours Required To Participate _____
 % of Employer Contribution for member _____ % of Contribution Member Pays _____
 % of Employer Contribution for Spouse _____ % of Employer Contribution for children _____ %
 Coverage Selection: Medical Medical & DD Death and Disability Only*

5. Non-Exempt Part-time Lay Employees: Waiting Period (not to exceed one year) _____ Hours Required To Participate _____
 % of Employer Contribution for Member _____ % of Contribution Member Pays _____
 % of Employer Contribution for Spouse _____ % of Employer Contribution for children _____ %
 Coverage Selection: Medical Medical & DD Death and Disability Only*

Dues Contribution and Coverage (Employers must contribute a mandatory 50% for employee dues. No mandatory contributions are required for family coverage.)

*Applies only if the member is waiving medical coverage

Employees are not permitted to waive medical coverage if the employer remits 100% of the employee cost.

Will any employees not be actively at work on the effective date of enrollment (i.e., Disability Workers' Compensation, etc.)? Yes No

If yes, please explain.

Workers' Compensation Insurance Does your organization have Workers' Compensation Insurance? Yes No

If no, please explain.

Optional Coverage Selection

Check the optional programs you will offer to employees: Retirement Savings Plan Long-Term Care Dental
 Supplemental Disability Supplemental Death

Retiree Coverage

Has your organization established formal retiree eligibility requirements for medical coverage? Yes No

If yes, please attach a copy of your formal written retiree medical eligibility requirements. If no, retirees requesting medical coverage through the Board of Pensions must meet the eligibility provisions of the Benefits Plan of the Presbyterian Church (U.S.A.).

 Employee Information

Please remember to **provide a payroll register**. Enrollment applications cannot be processed without a payroll register; return it with this employer agreement form.

Number of non-mandated employees:	All employees on payroll	Employees on payroll enrolling	Employees on payroll not enrolling due to:	
			Other coverage	Contribution requirement
Non-installed Ministers				
Exempt Full-time Lay				
Exempt Part-time Lay				
Non-Exempt Full-time Lay				
Non-Exempt Part-time Lay				
Totals				

Please list all enrolling employees. For each employee, please enclose a completed Affiliated Benefits Program Membership Application (ENR-002). If you need to list more employees, please attach a separate sheet of paper.

Employee _____ SSN _____

Creditable coverage certificate(s) enclosed.

Employee _____ SSN _____

Creditable coverage certificate(s) enclosed.

Employee _____ SSN _____

Creditable coverage certificate(s) enclosed.

Employee _____ SSN _____

Creditable coverage certificate(s) enclosed.

Employee _____ SSN _____

Creditable coverage certificate(s) enclosed.

D Agreement

I agree

- To abide by the Employer Provisions (ABP-201). View at Pensions.org.
- To remit the first month's payment with this form (only applies to non-PC(USA) employers),
- To remit employee and employer contributions in a timely manner to the Board of Pensions,
- **To notify the Board of Pensions within 30 days of any changes in service; retroactive enrollments will not be accepted.**
- To notify the Board of Pensions in writing at least 45 days prior to withdrawing all employees or all employees in a particular job classification from the Affiliated Benefits Program, that no employees withdrawn will be eligible for Medical Continuation coverage, and that all members with Affiliated Benefits Program Medical Continuation or Affiliated Benefits Program Medicare Supplement coverage will also be withdrawn from the Affiliated Benefits Program as a result of such withdrawal, and
- That if payments for Affiliated Benefits Program coverage are in arrears, the Board of Pensions may terminate coverage for these individuals enrolled in the Affiliated Benefits Program.

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. Further, I affirm that I am not aware of any conflicts of interest involving my position and my authorization allowing this employing organization to enroll in the Affiliated Benefits Program. If I am in a position 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.

Name *(print)* _____

Title _____ Daytime phone () _____

Signature _____ Date _____
(mm/dd/yyyy)

Please return this completed form, individual applications, certificates, and other forms to
The Board of Pensions of the Presbyterian Church (U.S.A.)
2000 Market Street, Philadelphia, PA 19103-3298
800-773-7752 (800-PRESPLAN)