

Dependent Coverage Waiver and Re-enrollment

Use this form to waive or re-enroll in the Medical Plan of the Presbyterian Church (U.S.A.) for an eligible spouse and/or dependent children if they have comparable medical coverage under other employer or military services-related group healthcare plans.

To receive a waiver, a member must file this application form, together with a copy of the summary plan description or other official description of the other medical benefits coverage, proof of medical coverage, and any other documentation the Board requests. The Board will determine whether the other medical coverage is comparable to the Medical Plan, using criteria outlined in Administrative Rule 206. If the waiver is accepted by the Board, the waiver will become effective the first of the month following the receipt of **all** required documentation.

This form should also be used for re-enrolling a spouse or dependent child. If re-enrolling a dependent, the effective date will be January 1 following an open enrollment or the date the dependent lost comparable coverage, as long as the Board receives an application for re-enrollment within sixty-three days of the loss of coverage.

Instructions:

- To *wave* Medical Plan coverage for an eligible spouse and/or dependent children, complete Sections A, B, and D of this form and furnish all required supporting documentation.
- To *re-enroll* a spouse or eligible dependent children, complete Sections A and C and include a certificate of creditable coverage.

A Member Information

Name _____ SSN _____

Home Address _____

City _____ State _____ Zip _____

Daytime Phone () _____ Home Phone () _____

Email *(optional)* _____

B Waive Dependent

List all eligible dependents to be waived from coverage under the Medical Plan. Attach a separate sheet if more space is needed.

Name *(first, middle, last)* _____ SSN _____

Date of birth *(mm/dd/yyyy)* _____ Gender M F Relationship _____

Reason for waiving dependent:

- Comparable coverage under other employer group healthcare plan
- Comparable coverage under military services-related group healthcare plan

Requested effective date of change *(mm/dd/yyyy)* _____

Check here to continue coverage for the dependent(s) if covered under the member's Optional Dental coverage or Supplemental Death Benefits coverage.

Check here to terminate coverage for the dependent(s) if covered under the member's Optional Dental coverage or Supplemental Death Benefits coverage. Optional coverage(s) will terminate effective the same date as the Medical Plan coverage.

Name *(first, middle, last)* _____ SSN _____

Date of birth *(mm/dd/yyyy)* _____ Gender M F Relationship _____

Reason for waiving dependent:

- Comparable coverage under other employer group healthcare plan
- Comparable coverage under military services-related group healthcare plan

Requested effective date of change *(mm/dd/yyyy)* _____

C Re-enrollment

A member may re-enroll a spouse or eligible dependent children for Medical Plan coverage under the following circumstances:

- during an annual open-enrollment period; the re-enrollment will take effect January 1 of the new Plan year.
- immediately upon loss of the other coverage; the reinstated Medical Plan coverage will become effective on the day after the other coverage terminated, as long as the Board receives a re-enrollment request within sixty-three days of the dependent's loss of coverage.

List all eligible dependents to be re-enrolled in the Medical Plan. Attach a separate sheet if more space is needed.

Name *(first, middle, last)* SSN

Date of birth *(mm/dd/yyyy)* Gender M F Relationship

Reason for re-enrolling

- Open enrollment
- Loss of coverage

If "Loss of coverage" is selected, please provide the reason for the loss and date that previous coverage terminated *(mm/dd/yyyy)*

Name *(first, middle, last)* SSN

Date of birth *(mm/dd/yyyy)* Gender M F Relationship

Reason for re-enrolling

- Open enrollment
- Loss of coverage

If "Loss of coverage" is selected, please provide the reason for the loss and date that previous coverage terminated *(mm/dd/yyyy)*

To qualify for re-enrollment of an eligible spouse and/or dependent(s), the member must complete this form and include a certificate of creditable coverage.

I apply to re-enroll the above-listed individuals for Medical Plan coverage.

Member's signature Date

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.).

Church/organization name PIN

Authorized signature Date

Authorized representative name *(print)* Title

D Waiver Authorization

- I confirm that the information provided on this form is true, correct, and complete to the best of my knowledge. I understand that I am waiving medical coverage under the Medical Plan of the Benefits Plan of the Presbyterian Church (U.S.A.) for dependent(s) listed above.
- I understand that this will not change the dues paid by the church or employing organization for the Medical Plan (with the exception of Affiliated Benefits Program members).
- I understand that I will only be able to re-enroll my dependent(s) for Medical Plan coverage (1) immediately, upon loss of his/her medical coverage, or (2) as of the following January 1, upon election by me to re-enroll my dependent(s) into the Medical Plan coverage. I will also be required to satisfy any other requirements of re-enrollment for my dependent(s) as set forth in Administrative Rule 206. I understand that if there is a gap in coverage of more than sixty-three days, my dependents' re-enrollment will be subject to the Plan's pre-existing condition provisions.
- I understand that I must notify the Board if I wish to re-enroll my dependents.
- I understand that my dependent(s) will still be eligible for participation in optional benefit coverages offered by the Board of Pensions, subject to Plan eligibility rules. I also understand that this waiver will not affect any other benefits in place for my dependent(s).

The effective termination of coverage date will be the first day of the month after all required documentation is received by the Board of Pensions. Due to the nature of this coverage termination, no Medical Continuation rights will be available.

Member's signature _____ Date _____

Spouse's signature, if applicable _____

E Employing Organization's Acknowledgement

The employee noted above is waiving dependent coverage for the listed dependents. I understand that this will not change the dues paid by the Church or employing organization (with the exception of Affiliated Benefits Program members).

Employer's signature _____ Date _____

Printed name _____ Title _____

Upon receipt of this form and completion of updates to your file, a Member Confirmation form will be sent to you for your records. Be sure to advise your healthcare providers that your dependent's coverage has changed so that his or her claims will be processed without delay.

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