

Dependent Change

Use this form to **ADD, REMOVE, or CHANGE** dependents. If adding dependents due to **marriage, adoption, or birth**, complete sections **A, B, and D**. Please report any additions to the Board within 31 days of the change. If the request is received after 31 days, the effective date of coverage will be the date the form is received at the Board of Pensions. If removing dependents due to **divorce, death, or change in dependent status**, complete sections **A, C, and D**. The change must be reported in advance of the removal request, otherwise the benefits for dependents will end the date the request is received.

This process can also be completed quickly and securely through Benefits Connect. Visit Pensions.org for more information.

Members' spouses and dependents are automatically enrolled for medical coverage in the Traditional program. Members may apply for a dependent coverage waiver for their spouses and dependents in certain circumstances. Please visit Pensions.org for more information.

A Member Information

Name _____ SSN _____

Home Address _____

City _____ State _____ Zip _____

Daytime Phone () _____ Home Phone () _____

Email *(optional)* _____

B Add Dependent

List all eligible dependents to be added under the Board of Pensions Medical Plan. Note: if you need additional space to add more dependents, please attach a separate sheet with your name, Social Security number, signature, date, the word "Dependent Change" and dependent information.

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

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

Reason for adding dependent

Marriage* Birth Adoption *(Include copy of letter of intent or adoption decree)*

Loss of eligibility of own employer-based coverage *(Include a copy of the Certificate of Creditable Coverage or letter from employer)*

Other *(Indicate reason for adding)* _____

Effective date of relationship *(mm/dd/yyyy)* _____

Check here if your dependent is currently enrolled in Medicare.

Check here if address of dependent is different from the member's. Please provide the address in the space below.

Street address _____

City _____ State _____ Zip _____

Phone () _____

Note: When adding a totally disabled child age 26 or over who is unable to live independently even in a supportive environment, medical verification will be requested.

Check here to add a dependent(s) to member's Optional Dental coverage (subject to plan eligibility rules). If dental coverage level is changing, a dental application will be sent to you for completion.

* If other coverage is/was in effect, please submit a Certificate of Creditable Coverage, which could reduce or eliminate the 12-month pre-existing condition limitation.

C Remove Dependent

List all dependents to be removed from the Board of Pensions Medical Plan. Attach a separate sheet if more space is needed.

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

Reason for removing dependent:

- Divorce *(Include copy of divorce decree)* Death *(Include copy of death certificate or obituary)*
 Eligible for own employer-based coverage Other *(Reason)* _____

Effective date of change *(mm/dd/yyyy)* _____

Check here if address of dependent is different from the member's. Please provide the address in the space below.

Street address _____

City _____ State _____ Zip _____

Phone () _____

D Authorization

My signature confirms the accuracy of the information reported on this form. If adding a spouse or child(ren), my signature also certifies and confirms that my spouse and/or children are eligible for plan benefits as defined by the Benefits Plan of the Presbyterian Church (U.S.A.), and that my children do not have access to their own employer-based coverage. If this information changes, I will immediately notify The Board of Pensions of the Presbyterian Church (U.S.A.).

Note:

- Adding or removing a dependent(s) is an opportune time to review your beneficiary designations. Please take a moment to review your current designations to determine if you would like to make changes or updates.
- As a member, you are eligible to subscribe for the Optional Dental and Supplemental Death Benefit coverage if you experience one of the following events and report the change to the Board within 31 days:
 - a change in marital status
 - the addition of a new child as a dependent

To receive additional information about this benefit or to request the appropriate forms, please contact the Board at 800-773-7752 (800-PRESPLAN), or visit Pensions.org.

Upon receipt of this form and completion of updates to your file, a Member Confirmation form will be sent to you for your records.

Member Signature *(required)* _____ Date *(mm/dd/yyyy)* _____

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 _____

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