

**Affiliated Benefits Program Service/Salary Change**

Please use this form to report all changes in service or salary within 31 days of any change. Print legibly in ink or type. An authorized signature on the form confirms that the employing organization agrees to pay all required dues for medical or medical and death and disability coverage to the Board of Pensions. (The clerk of session, treasurer, business manager, or financial secretary may be authorized.)

**A Member Information**

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

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Daytime phone (     ) \_\_\_\_\_ Email \_\_\_\_\_

**Reason for change:** Please check and complete Sections A, E, and the sections noted.

- Change of position at current service (Sections A, B, C, E, and D, if applicable)
- Change of salary at current service (Sections A, B, C, E)
- New service (Sections A, B, C, D, E)
- Other *(please specify)* \_\_\_\_\_

**B Service/Salary Information**

Church/organization name \_\_\_\_\_ PIN \_\_\_\_\_

Address \_\_\_\_\_ Phone (     ) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Presbytery \_\_\_\_\_ Synod \_\_\_\_\_

- Exempt\* lay employee
- Non-exempt\* lay employee

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

Position Title \_\_\_\_\_ Position Code \_\_\_\_\_

Total hours scheduled to work per week *(e.g. 20, 35, 40)* \_\_\_\_\_ Service/Salary effective date \_\_\_\_\_

## **C Annual Salary Information**

Salary information determines Medical Plan deductible and copayment maximums.

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) \$ \_\_\_\_\_
- 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.

## **D Selection of Coverage**

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.

**Please check one:**     Medical Plan                       Medical, Death and Disability Plan\*     Death and Disability, if waiving Medical\*

\* Please also complete a Death Benefits Beneficiary Designation form (DBN-001)

**Medical Plan** (Please check one level:)

- Single coverage       Member and spouse       Member and children       Member and family

**Optional Dental Benefit** (If offered by your employer)

Please refer to the Healthcare Coverage booklet for restriction and eligibility requirements. To elect this option, please check one:

- Yes, I am interested in enrolling. Please send me information on the options available and an application for completion.
- Yes, I am interested in enrolling and my application is enclosed.
- No, I am not interested in enrolling at this time. I understand that I will only be able to enroll at a later date if I have a life-change event or if there is an open enrollment as outlined in the Healthcare Coverage booklet. I also understand that I may have a 12-month limitation on dental services.

**Supplemental Death Benefit, only allowed with Death and Disability coverage**

Complete and attach the Supplemental Death Benefits Enrollment, ODB-000, and Supplemental Death Benefit Beneficiary Designation, ODB-002. For certain coverage levels, you must complete and attach the Supplemental Death Benefit Medical Statement, ODB-001, or ODB-001A.

**403(b)(9) Retirement Savings Plan - If your employer agrees to your participation, please call the Board for information and forms at 800-773-7752 (800-PRESPLAN).**

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**E Authorization**

By signing this form, the authorized representative of the employing organization confirms that the organization agrees to pay all required dues for benefits. The authorized representative may be the treasurer, clerk of session, business manager, or financial secretary, but not the member submitting the change.

**I confirm the accuracy of the information in this form.**

Member signature *(required)* \_\_\_\_\_ Date \_\_\_\_\_

Authorized employer representative *(please print)* \_\_\_\_\_  
*(cannot be the same as the member)*

Official capacity \_\_\_\_\_ Daytime phone ( \_\_\_\_\_ ) \_\_\_\_\_

Authorized employer representative's signature *(required)* \_\_\_\_\_ Date \_\_\_\_\_

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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