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

ENR-107
Rev. 1/11

Affiliated Benefits Program Dependent Change

To add or remove a dependent, complete the appropriate sections below. If you check "Other," please write the reason in the space provided.

If a life change event is reported within 60 days, the dependent will be added as of the date the relationship began. If a life change event is reported later than 60 days, you will need to enroll the dependent on the church/employing organization's anniversary date.

Note: If you are enrolled for death benefits, you should consider whether or not you also want to change your beneficiary designations as a result of any dependent changes.

A Member's Information *(Please print or type and complete all information.)*

Name ______ SSN ______

Home address ______

City ______ State ______ Zip ______

Daytime phone (   ) ______ Cell (   ) ______ Home phone (   ) ______

Email address ______ ☐ Check here if you are an HMO participant

B Add Dependent To *(Subject to plan rules)* ☐ Medical ☐ Dental

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

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

Home address ______

City ______ State ______ Zip ______

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 other medical coverage*

☐ Other *(indicate reason for adding)* ______

Effective date of life change event *(mm/dd/yyyy)* ______

☐ Check here if your dependent is currently enrolled in Medicare.

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

Home address ______

City ______ State ______ Zip ______

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 other medical coverage*

☐ Other *(indicate reason for adding)* ______

Effective date of life change event *(mm/dd/yyyy)* ______

☐ Check here if your dependent is currently enrolled in Medicare.

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

***** Please submit a Certificate of Creditable Coverage, which could reduce or eliminate the 12-month pre-existing condition limitation.

C Remove Dependent From *(Subject to plan rules)* ☐ Medical ☐ Dental

Name *(first, middle, last)* SSN

Home address

City State Zip

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

Reason for removing dependent:

☐ Divorce *(Include copy of divorce decree)* ☐ Death *(Include copy of death certificate or obituary)*

☐ New medical coverage ☐ Other *(reason)* ______

Effective date of life change event *(mm/dd/yyyy)**

Name *(first, middle, last)* SSN

Home address

City State Zip

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

Reason for removing dependent:

☐ Divorce *(Include copy of divorce decree)* ☐ Death *(Include copy of death certificate or obituary)*

☐ New medical coverage ☐ Other *(reason)* ______

Effective date of life change event *(mm/dd/yyyy)**

* Retroactive changes are not permitted. The benefits for dependents will end on the last day of the month in which the notification to terminate dependent coverage is received. If employer/employee fails to report changes in advance of or immediately upon the actual termination date, and the spouse/dependent accesses medical or dental benefits after the notification of termination is received, the employer will be responsible for the appropriate dues.

D Authorization

I confirm the accuracy of the information reported on this form.

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

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

When we receive this form and record the information in your record, you will receive a Member Confirmation Form to verify the accuracy of your record.