

Medicare Supplement Subscription, Waiver, or Withdrawal

Before completing this form, please refer to the Medicare Supplement product sheet (PTS-606) for eligibility requirements, including a definition of the Rule of 70, waiver implications, and other important information. (This form is available at Pensions.org or by calling the Board of Pensions.) Your eligibility for Medicare Supplement benefits will be reviewed upon receipt of this completed form.

Instructions: To *enroll* in Medicare Supplement coverage, complete Sections A, B, and C. To *waive* Medicare Supplement coverage, complete Sections A and D. To *withdraw* from Medicare Supplement coverage, complete Sections A and E.

A Your Personal Information

Name *(first, middle, last)* SSN

Spouse's name *(first, middle, last)* SSN

If you are not the member, please complete:

Member's name *(first, middle, last)* SSN

Note: If your address has changed or will soon change, please complete and submit a Change of Address form (ENR-106).

B Subscription

I want to subscribe for the Medicare Supplement. I am at least 65 years of age or disabled and participate in Medicare Parts A and B.

I want to subscribe as a *(check one)*:

Retired member Retired member's spouse Surviving spouse Divorced spouse

I wish to enroll the following individuals, including myself. Each subscriber pays dues.

Name <i>(first, middle, last)</i>	Birth date	Relationship	SSN
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Name <i>(first, middle, last)</i>	Birth date	Relationship	SSN
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Name <i>(first, middle, last)</i>	Birth date	Relationship	SSN
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Name <i>(first, middle, last)</i>	Birth date	Relationship	SSN
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Use a separate sheet if necessary.

Social Security Act Medicare Health Insurance cards *(check one)*:

- I have attached copies of Social Security Medicare health insurance cards showing enrollment in both Parts A and B for each subscriber.
- I have applied for but have not yet received Social Security Medicare health insurance cards.

C Subscription Authorization

I elect to subscribe for the Medicare Supplement coverage of the Benefits Plan of the Presbyterian Church (U.S.A.) (Article XIV, Section 14.3). I authorize the Board of Pensions to deduct subscription charges from my pension benefit check. If I am not receiving a pension benefit or the payment amount does not cover the monthly cost of the subscription, I agree to pay the dues and authorize the Board of Pensions to bill me monthly, in advance, for this coverage.

Method of Payment *(check one):*

- I wish to have deductions made from my pension check for the full cost of this coverage.
- I have enclosed a check to pay for the cost of this coverage through the current month plus one month in advance. *If you wish to have future monthly payments deducted from your bank account via BoardLink®, visit Pensions.org or call 800-773-7752 (800-PRESPLAN) for more information.*

I understand that I may permanently terminate this subscription at any time by sending **advance** written notice to the Board of Pensions. Otherwise, my subscription will terminate on the date the request is received. If I fail to pay any subscription charge within 30 days of its due date, coverage is permanently terminated. I also understand that if I terminate my coverage, no re-election is possible at a later date.

Signature of member/subscriber *(required)*Date *(mm/dd/yy)*

Signature of spouse *(if applicable)*Date *(mm/dd/yy)*

D Application and Authorization for Waiver of Coverage *(complete only if waiving coverage)*

I am applying for a waiver of Medicare Supplement coverage under the Benefits Plan of the Presbyterian Church (U.S.A.) as the member and/or spouse of the member listed, the divorced spouse, or the surviving spouse. I also certify that the member and/or spouse's, divorced spouse's, or surviving spouse's employer(s) is/are providing group medical coverage. I am attaching **a copy of the member and/or spouse's medical benefits identification card(s)** from the other employer(s).

Name of the employer providing medical coverage during the waiver period.

- I wish to waive only my coverage now *(member or former spouse must sign below)*
- We wish to waive only my spouse's coverage now *(both member and spouse must sign below)*
- We both wish to waive coverage now *(both member and spouse must sign below)*

I/we understand and accept that:

- If the Board of Pensions approves this application, the Board will pay no medical benefits whatsoever for the above-named member and/or spouse during the effective term of this waiver.
- The Board can reinstate coverage under the Medicare Supplement benefits for the member and/or spouse only at the time of one of these qualifying events: the death of the member and/or spouse, the involuntary loss of medical coverage, retirement, or termination of other employment.

We also understand that we must apply for coverage within 90 days of the qualifying event. If there is a gap in medical coverage of 63 days or more, pre-existing conditions may not be covered.

I/we hereby release the Board of Pensions from any and all liability resulting from relying and acting upon the information supplied on this waiver application.

Signature of member/subscriber *(required)*Date *(mm/dd/yy)*

Signature of spouse *(required)*Date *(mm/dd/yy)*

E Withdrawal from Medicare Supplement Request and Authorization

I/we withdraw from the Medicare Supplement in order to participate in a Medicare Advantage option. I/we understand that completing this form only withdraws us from the Medicare Supplement; it does not enroll us in a Medicare Advantage option. To enroll, I/we must contact that organization directly.

Coverage termination date* (mm/dd/yy)

- I wish to withdraw my coverage now (member or former spouse must sign below)
- We wish to withdraw my spouse's coverage now (both member and spouse must sign below)
- We both wish to withdraw now (both member and spouse must sign below)

I authorize the Board of Pensions to end my participation in the Medicare Supplement because I am subscribing to a Medicare Advantage option and I understand that

- I will be eligible to re-enroll in the Medicare Supplement only if
 - I decide within 12 months of withdrawal that the Medicare Advantage option is not meeting my needs
 - I permanently relocate outside the Medicare Advantage service area
 - the Medicare Advantage option ceases to offer coverage to Medicare-eligible participants, or
 - the Medicare Advantage option significantly changes my benefits or premiums (subject to review and approval).
- To re-enroll in the Medicare Supplement, I must be eligible for re-enrollment, apply to the Board of Pensions within 90 days of my termination from the Medicare Advantage option, and provide proof of terminating coverage from the Medicare Advantage option and of re-establishing coverage under traditional Medicare Part A and Part B. If there is a gap in medical coverage of 63 days or more, pre-existing conditions may not be covered.
- The Board of Pensions reserves the right to terminate the right to return to the Medicare Supplement at any time.

*This is the last day you will be covered under the Board's active or Medical Continuation medical coverage or Medicare Supplement. Because coverage is offered in monthly segments, the end date must be the last day of the month before you join a Medicare Advantage option.

Signature of member/subscriber (required)

Date (mm/dd/yy)

Signature of spouse (required)

Date (mm/dd/yy)

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