

Supplemental Death Benefits Application

Please print or type all information, sign the form, and obtain appropriate authorized signature. Members must also complete and sign a Supplemental Death Benefits Medical Statement (Member) (ODB-001) (member does not need to complete if applying for \$25,000 or \$50,000 coverage level during initial enrollment in the Benefits Plan), and a Supplemental Death Benefits Beneficiary Designation form (ODB-002). Spouses must also complete and sign a Death Benefits Medical Statement (Spouse)(ODB-001A).

The Board reserves the right to deny enrollment in the program if the information provided on the Supplemental Death Benefits Medical Statement fails to meet the Board's underwriting criteria. This coverage is not available to seminary students.

A Member Information *(must complete)* *(If a member couple, please see reverse side)*

Name _____ SSN _____

Address _____ City _____ State _____ Zip _____

Phone () _____ Email _____

Employer _____ PIN _____

Address _____ City _____ State _____ Zip _____

Phone () _____ Email _____

Member Coverage

1. Have you used any tobacco products within the last 12 months? *(check one)* Yes No
2. I want to *(check one)* Apply for new coverage Increase coverage level Decrease coverage level Discontinue coverage
3. The new coverage level I choose is *(check one, if applicable)*
 \$25,000 \$50,000 \$75,000 \$100,000 \$150,000 \$200,000 \$250,000 \$300,000

B Spouse Information *(complete only if applying for coverage)*

Name _____ SSN _____

Spouse Coverage *(complete only if applying for coverage)*

1. Have you used any tobacco products within the last 12 months? *(check one)* Yes No
2. I want to *(check one)* Apply for new coverage Increase coverage level
 Decrease coverage level Discontinue coverage
3. The new coverage level I choose is *(check one, if applicable)* \$25,000 \$50,000 \$75,000 \$100,000

C Children's Coverage *(covers all eligible children as defined by the Benefits Plan)*

The coverage level I choose is *(check one, if applicable)* \$5,000 \$10,000

D Authorization

I understand that the Board of Pensions will bill my employing organization for all the costs of the Supplemental Death Benefits coverage, and I consent to my employer deducting these dues from my pay. The Board will continue to bill for this voluntary optional coverage until I instruct the Board in writing to discontinue coverage. The employing organization agrees to regularly remit in advance, on the basis of the information on this form, all required dues to the Board of Pensions. If I have checked tobacco free, I or my spouse have never used tobacco products or have not done so for the past 12 months. I understand that I must complete a tobacco use declaration form if my status changes.

Signature of member *(required)* _____ 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.) and agree to pay all required dues to the Board of Pensions by the due date.

Authorized Employer Signature *(required)* _____ Date _____

Please print name and title of Authorized Employer Representative _____

Coverage selected at initial enrollment is effective the same date as the member's participation in the Benefits Plan of the Presbyterian Church (U.S.A.). Coverage selected at the start of a new service is effective the same date as the new service. Coverage selected during the open enrollment period is effective January 1. For coverage to become effective, the member must be actively at work; a spouse or unemployed member must not be confined or disabled. Applications may be submitted during the open enrollment; the applicant should notify the Board in writing when no longer confined or disabled.

Member Couples may enroll for coverage in the Supplemental Death Benefits program either as a member or a spouse: they cannot enroll as a member and a spouse. Only one member may enroll dependent children. Please refer to your Member Couple Booklet for guidelines when experiencing a life change event. You may contact the Board at 800-773-7752 (800-PRESPLAN) for a copy of the booklet.

Current Supplemental Death Benefits Program Rates

Non-Tobacco User Annual Rates

Age	Member and Spouse Rates				Member Only Rates			
	\$25,000	\$50,000	\$75,000	\$100,000	\$150,000	\$200,000	\$250,000	\$300,000
Under 29	15	30	45	60	90	120	150	180
30 - 34	19	38	57	76	114	152	190	228
35 - 39	24	48	72	96	144	192	240	288
40 - 44	30	60	90	120	180	240	300	360
45 - 49	45	90	135	180	270	360	450	540
50 - 54	69	138	207	276	414	552	690	828
55 - 59	129	258	387	516	774	1,032	1,290	1,548
60 - 64	198	396	594	792	1,188	1,584	1,980	2,376
65 - 69	315	630	945	1,260	1,890	2,520	3,150	3,780
70 - 74	480	960	1,440	1,920	2,880	3,840	4,800	5,760
75 - 79	585	1,170	1,755	2,340	3,510	4,680	5,850	7,020
80 - 84	618	1,236	1,854	2,472	3,708	4,944	6,180	7,416
85 - 89	618	1,236	1,854	2,472	3,708	4,944	6,180	7,416
90 - 94	618	1,236	1,854	2,472	3,708	4,944	6,180	7,416
95 +	618	1,236	1,854	2,472	3,708	4,944	6,180	7,416

Tobacco User Annual Rates

Age	Member and Spouse Rates				Member Only Rates			
	\$25,000	\$50,000	\$75,000	\$100,000	\$150,000	\$200,000	\$250,000	\$300,000
Under 29	23	46	69	92	138	184	230	276
30 - 34	32	64	96	128	192	256	320	384
35 - 39	42	84	126	168	252	336	420	504
40 - 44	62	124	186	248	372	496	620	744
45 - 49	107	214	321	428	642	856	1,070	1,284
50 - 54	191	382	573	764	1,146	1,528	1,910	2,292
55 - 59	329	658	987	1,316	1,974	2,632	3,290	3,948
60 - 64	400	800	1,200	1,600	2,400	3,200	4,000	4,800
65 - 69	526	1,052	1,578	2,104	3,156	4,208	5,260	6,312
70 - 74	773	1,546	2,319	3,092	4,638	6,184	7,730	9,276
75 - 79	877	1,754	2,631	3,508	5,262	7,016	8,770	10,524
80 - 84	1,163	2,326	3,489	4,652	6,978	9,304	11,630	13,956
85 - 89	1,540	3,080	4,620	6,160	9,240	12,320	15,400	18,480
90 - 94	1,978	3,956	5,934	7,912	11,868	15,824	19,780	23,736
95 +	2,411	4,822	7,233	9,644	14,466	19,288	24,110	28,932

Dependent Children Annual Dues*

\$5,000 Coverage	\$10,000 Coverage
\$16	\$32

* Dues cover all eligible dependent children in the family, as defined by the Benefits Plan.

Note: Displayed rates may be rounded.

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