Seminary Student Benefits Plan Membership Application

Please complete this form and return it to the Board of Pensions to enroll in the Medical Plan. A full-time seminary student designated by a presbytery as a candidate or an inquirer and not otherwise employed in eligible service may enroll for coverage in the Medical Plan. Please print legibly in ink or type information.

To enroll in the Benefits Plan, the Board of Pensions must receive your completed and SIGNED application that has been postmarked during the open enrollment periods. **The open enrollment is August 1 to September 30** or, if you first enroll at the seminary during the spring semester, 30 days from the date the semester begins. The Board will only accept enrollment applications within these open enrollment periods. Please remit:

1. The first month's payment to activate coverage.
2. Written verification from your presbytery that you are an inquirer or candidate for ordination.
3. Written verification from your seminary that you are enrolled as a full-time student.

Please see the enclosed Seminary Student Checklist or visit Pensions.org for dues information.

A Applicant Information

Name SSN

Mailing address *(Please include street address if mailing address is a P.O. Box.)*

City State Zip

Permanent address *(If different from your mailing address)*

City State Zip

Daytime phone ( ) Home phone ( )

Fax ( ) Email Citizenship *(if other than U.S.)*

Birthdate *(mm/dd/yy)* ☐ Male ☐ Female ☐ Single ☐ Married Date of Marriage *(mm/dd/yy)*

Please list an alternate contact (a person who can reach you at any time)

Name Daytime phone ( )

Address

Presbytery of care Seminary

B Effective Date

The coverage automatically takes effect the first of the month following the Board's receipt of the application. The effective date cannot be retroactive. This completed application must be postmarked within the established open enrollment periods.

Plan membership requested effective date:

☐ September 1 ☐ October 1 ☐ Spring semester ☐ New candidate

(The spring semester begins on mm/dd/yy) *(Presbytery approved candidacy on mm/dd/yy)*

☐ New or Transfer Student *(mm/dd/yy)* Anticipated date of graduation *(mm/dd/yy)*

Spouse and Dependent Information

Spouse's full name SSN Spouse's Birthdate *(mm/dd/yy)*

☐ Check here if your spouse is also a member of the Benefits Plan as a result of her/his employment.

Please list all children including all non-custodial dependent children up to age 26. Include the status and relationship codes as needed. To list additional dependents, attach a separate sheet of paper.

Relationship Codes: **S:** Son **SS:** Stepson **D:** Daughter **SD:** Stepdaughter **LW:** Legal Ward

Status Codes: **DS:** permanently disabled age 26 or over and unable to live independently even in a supportive environment. Medical verification needed.

Full Name & Address *(address if different from member's address)*	**SSN**	**Birthdate**	**Gender**	**Relationship**	**Status**

Selection of Coverage

Select Medical Benefits coverage: *(Please check one level.)*

☐ Member only ☐ Member and spouse ☐ Member and children only ☐ Member and family

Previous Medical Coverage

I had coverage under a previous employer/insurance carrier. ☐ Yes ☐ No

A Certificate of Creditable Coverage verifying the coverage is attached. ☐ Yes ☐ No

My spouse and dependent children also had prior coverage. ☐ Yes ☐ No

Certificates of Creditable Coverage are attached. ☐ Yes ☐ No

The certificate is provided by an employer to show the dates of previous medical coverage. It is required to determine the time to be credited for any pre-existing condition limitation that may otherwise apply. **Expenses for treatment of pre-existing conditions will not be covered for the first 12 months. Prior coverage documented by a certificate may reduce the limitation period.**

Please note that the pre-existing limitation does not apply to children under the age of 19.

If you, your spouse, or dependents are covered under any other group medical coverage, please complete:

Name of family member ______________________________

Employer name ______________________________ Employer phone (   ) ______________

Employer address ______________________________

City ______________________________ State ________ Zip ____________

Insurance carrier ______________________________ Group # ______________

Address ______________________________

City ______________________________ State ________ Zip ____________

Policy or ID# ____________________ Effective date ____________ Phone (   ) ____________

Policy covers: ☐ Applicant ☐ Spouse ☐ Children

Type of benefits *(for example, medical, dental, prescription)* ______________________________

C Authorization

I/We confirm that the information provided in this application is true, correct, and complete to the best of my/our knowledge. My/Our signature(s) 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.). In accordance with the Benefits Plan, I agree to furnish any information the Board needs in connection with any medical claim for a family member or me, including information about any other group medical coverage.

I/We hereby consent to the release of my personal health information and, if applicable, that of my dependent children to the Board's representatives and agents, including without limitation, ActiveHealth Management, CIGNA Behavioral Health, Express Scripts, and Highmark, their successors and assignees, for the purpose of paying claims and administering the Medical Plan.

I also understand that I will be billed for coverage a month in advance and must pay the bill for coverage to continue. If I do not pay for two consecutive months, I understand that my coverage will be terminated without right of reinstatement. I authorize the Board to report to the seminary suspension of my Medical Plan participation for non-payment of dues.

Applicant's signature *(required)* ______________________________ Date ____________

Spouse's signature *(if applicable)* ______________________________ Date ____________

Please send the completed application form to:

The Board of Pensions of the Presbyterian Church (U.S.A.)
2000 Market Street, Philadelphia, PA 19103-3298

If you have questions, you may contact us at

800-773-7752 (800-PRESPLAN)
Fax 215-587-6215 TDD 877-522-7948
Pensions.org