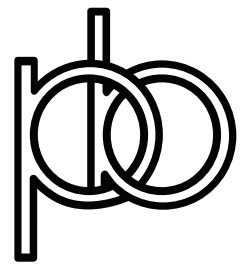


The Pension Boards  
United Church of Christ



475 Riverside Drive  
Room 1020  
New York, NY 10115-0059

p 800.642.6543  
f 212.729.2701

www.pbucc.org  
info@pbucc.org

**Medical Benefits Enrollment Application**

PARTICIPANT INFORMATION					
Social Security Number	First name	Middle initial	Last name		
Address 1		City	State	Zip	Country
Address 2					
Address 3		E-mail Address			
Telephone Number					
Marital Status: <input type="checkbox"/> Single                      Same-Gender: <input type="checkbox"/> Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Civil Union <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partnership		Do you or any member(s) of your family have other medical coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list carrier name and address:			
PROVIDE PARTICIPANT AND DEPENDENT(S) INFORMATION BELOW					
(Use additional sheet if necessary)					
Name <i>(last, first, middle initial)</i>	Relationship to participant	Date of birth <i>(mm/dd/yr)</i>	Social Security Number	Gender <i>(M/F)</i>	
	Self		XXX-XX-XXXX		
	Spouse/Partner				
<p><b>Participant:</b> Please read and sign below. (Unsigned applications will be returned.)                      I certify that the adult child(ren) listed above is (are) not eligible to enroll in an eligible employer-sponsored health plan. If my status or my dependent's status changes, I agree to notify the Pension Boards immediately. I hereby enroll in the UCC Medical Benefits Plan Option indicated below.  <b>Selected Medical Benefits Plan Option (check one only):</b>            <input type="checkbox"/> Plan A            <input type="checkbox"/> Plan B            <input type="checkbox"/> Plan C</p>					
SIGNATURE					
Participant's signature			Date		
TO BE COMPLETED BY EMPLOYER					
(if applicable, see reverse)					
Name of employer		Date of hire		Hours worked per week	
Address (number and street)			Signature		
City/State/ZIP			Date signed		

Please return the original to the Pension Boards, and retain a copy for your records.

## INSTRUCTIONS

Please complete all required information and sign your enrollment application. Any incomplete, unsigned application will be returned and not accepted by the Pension Boards.

Eligible employees must enroll in the UCC Medical Benefits Plan within 90 days of initial UCC employment.

**“Participant”** means the primary subscriber who is enrolled in and covered by the UCC Medical Benefits Plan.

**“Dependent(s)”** includes the spouse or same-gender domestic partner and children.

**Employer Signature** is required if UCC Medical Benefits Plan contribution rates are paid by the employer.

Please be sure to list all dependents to be covered under your policy with the UCC Medical Benefits Plan. Use an additional sheet of paper if necessary.

### QUESTIONS? NEED ASSISTANCE?

The Pension Boards staff is available to assist you in this important process. Please feel free to contact a Member Services Representative toll-free at **800.642.6543, Option 6**, or by e-mail at **info@pbucc.org**.

The Pension Boards administers  
comprehensive employee benefits programs  
for the United Church of Christ,  
providing the highest standards of service,  
access and options to active and retired  
UCC clergy and lay employees.

Please return the original to the Pension Boards, and retain a copy for your records.