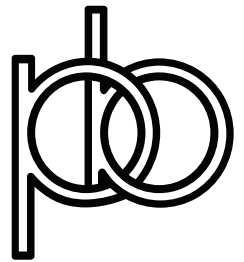


The Pension Boards
United Church of Christ



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

p 800.642.6543
f 212.729.2701

www.pbucc.org
info@pbucc.org

UCC Vision Benefits Plan 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 vision 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 (last, first, middle initial) | Relationship to participant | Date of birth (mm/dd/yr) | Social Security Number | Gender (M/F) |
|---------------------------------------|-----------------------------|-----------------------------|------------------------|-----------------|
| | Self | | XXX-XX-XXXX | |
| | Spouse/Partner | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Participant: 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 Vision Benefits Plan Plan option indicated below.

| | |
|--|--|
| Single Adult <input type="checkbox"/> \$ 90.00 | One Adult with Child(ren) <input type="checkbox"/> \$147.60 |
| Two Adults <input type="checkbox"/> \$165.60 | Two Adults with Child(ren) <input type="checkbox"/> \$224.40 |

Vision Plan premiums are payable in one annual payment due with application. (See reverse for instructions)

EMPLOYER INFORMATION

| | | |
|-----------------------------|--------------|-----------------------|
| Name of employer | Date of hire | Hours worked per week |
| Address (number and street) | | City/State/Zip |

SIGNATURE

| | |
|-------------------------|------|
| Participant's signature | Date |
|-------------------------|------|

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 and return it with the appropriate annual premium amount to:

THE PENSION BOARDS - UNITED CHURCH OF CHRIST
75 REMITTANCE DRIVE, SUITE 1592
CHICAGO, IL 60675-1592

Incomplete and/or unsigned applications cannot be processed by the Pension Boards and will be returned.

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

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

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

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.