The Pension Boards - United Church of Christ
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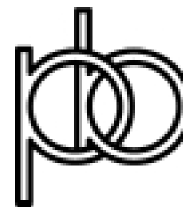

An Affiliated Ministry of the United Church of Christ

Fill out and submit this form if there has been a change in your health coverage status.

Health Coverage Change Form

Social Security No.	Name *(last, first, middle initial)*	Conference No.

Address *(no. and street)*	City, State, Zip

Phone No. *(with area code)*	E-mail Address	Date of Birth *(month, day, year)*

Male ☐ Female ☐	Will you have any other coverage (including Medicare) while enrolled with UCC? Yes ☐ No ☐ If yes, carrier name

Name of Policy Holder	Policy start date *(m,d, y)*	Effective Date

Please choose one of the following eight (8) health classes to indicate your new coverage status.

1 ☐ Member only under 65
2 ☐ Member & Dependent All Under 65
3 ☐ Member only 65 and over
4 ☐ Member and Spouse/Partner both 65 and over
5 ☐ Member 65 and over; all dependents under 65
6 ☐ Member under 65; Spouse/Partner 65 and over
7 ☐ Surviving Spouse/Partner under 65
8 ☐ Surviving Spouse/Partner 65 and over

To be completed by Employer

Name of Employer	Group No. UC00

Date of full-time employment *(20 or more hours per week)*	Average no. of hours worked per week	Employee Occupation Minister ☐ Layworker ☐

Employer Signature	Date

Employee's Dependent Information (Only for dependents to be covered on your UCC Health Plan)

For Spouse/Same-Gender Domestic Partner

Social Security No.	Name *(last, first, middle initial)*	Date of Birth *(m,d,yr)*

Address *(no. and street)*	City, State, Zip	Male ☐ Female ☐

Date of Marriage /Partnership*(m,d,yr)*	Will you have any other coverage (including Medicare) while enrolled with UCC? Yes ☐ No ☐ If yes, carrier name

Name of Policy Holder	Policy start date *(month, day, year)*

For Eligible Child(ren)

Social Security No.	Name *(last, first, middle initial)*
Address *(no. and street)*	City, State, Zip
Date of Birth *(month, day, year)*	Male ☐ Female ☐	Relationship
Will you have any other coverage (including Medicare) while enrolled with UCC? Yes ☐ No ☐ If yes, carrier name	
Name of Policy Holder	Policy start date *(month, day, year)*
Is this dependent disabled? Yes ☐ No ☐	Student information for dependent age 19 and older *(Provide proof of full-time attendance)*

Social Security No.	Name *(last, first, middle initial)*
Address *(no. and street)*	City, State, Zip
Date of Birth *(month, day, year)*	Male ☐ Female ☐	Relationship
Will you have any other coverage (including Medicare) while enrolled with UCC? Yes ☐ No ☐ If yes, carrier name	
Name of Policy Holder	Policy start date *(month, day, year)*
Is this dependent disabled? Yes ☐ No ☐	Student information for dependent age 19 and older

Please go to page 3 to add additional dependents.
In order to help us quickly process this form and avoid delays, make sure all areas are properly filled out.

Check the appropriate box.

I hereby enroll in the United Church of Christ Health Benefits Plan. If my status or my dependent(s)' status changes, I agree to notify the Pension Boards - United Church of Christ immediately.

I will enroll ☐ will not enroll ☐ in the United Church of Christ Dental Benefits Plan at this time. I understand that if I do not enroll in the Dental Benefits Plan at the same time I enroll in the Health Benefits Plan, I will be required to wait for the next period of open enrollment to apply for coverage under this Plan.

Employee/Applicant Signature	Date

Employee/Applicant Signature	Date

Social Security No.	Name *(last, first, middle initial)*
Address *(no. and street)*	City, State, Zip
Date of Birth *(month, day, year)* ☐ ☐	Relationship
Will you have any other coverage (including Medicare) while enrolled with UCC? Yes ☐ No ☐ If yes, carrier name	
Name of Policy Holder	Policy start date *(month, day, year)*
Is this dependent disabled? Yes ☐ No ☐	Student information for dependent age 19 and older

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Social Security No.	Name *(last, first, middle initial)*
Address *(no. and street)*	City, State, Zip
Date of Birth *(month, day, year)* ☐ ☐	Relationship
Will you have any other coverage (including Medicare) while enrolled with UCC? Yes ☐ No ☐ If yes, carrier name	
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Social Security No.	Name *(last, first, middle initial)*
Address *(no. and street)*	City, State, Zip
Date of Birth *(month, day, year)* ☐ ☐	Relationship
Will you have any other coverage (including Medicare) while enrolled with UCC? Yes ☐ No ☐ If yes, carrier name	
Name of Policy Holder	Policy start date *(month, day, year)*
Is this dependent disabled? Yes ☐ No ☐	Student information for dependent age 19 and older