



# Dental Benefits Plan

## Open Enrollment Application

**EMPLOYER ID:** \_\_\_\_\_ [ ] **NEW EMPLOYER**  
**MEMBER ID:** \_\_\_\_\_ [ ] **EXISTING MEMBER\***

\*If you are an existing member and/or annuitized your previous account, please provide your Member ID number above, and your name in the Personal Information section below.

UCC Dental Plan is offered to employees and retirees who do not currently have dental coverage, or who have coverage in a plan other than the UCC's.

Coverage is available to individuals who are currently employed by a UCC church or UCC-related entity, or retired clergy or lay employees who were previously employed full-time by a UCC church or UCC-related entity. If you are employed your Employer must sign the form.

### PERSONAL INFORMATION

SSN: \_\_\_\_\_ Gender: [ ] M [ ] F Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Title: [ ] Rev. [ ] Dr.  
 Relationship Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Civil Union [ ] Domestic Partner  
 Name of Member (last, first, middle initial): \_\_\_\_\_  
 Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_ Email: \_\_\_\_\_

### SPOUSE / PARTNER INFORMATION (if applicable)

Name of Spouse / Partner (last, first, middle initial): \_\_\_\_\_  
 SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Marriage: \_\_\_\_/\_\_\_\_/\_\_\_\_

### EMPLOYEE INFORMATION

Employee Type: [ ] Clergy [ ] Lay For Clergy Only - Ordination Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Employment Type: [ ] Full Time [ ] Part Time [ ] Contract Average Hours Worked Per Week: \_\_\_\_\_  
 Conference: \_\_\_\_\_ Self Employed: [ ] Y [ ] N  
 Date of Hire: \_\_\_\_/\_\_\_\_/\_\_\_\_

**DEPENDENT INFORMATION FOR INSURANCE**

1. Name of Dependent (last, first, middle initial): \_\_\_\_\_ Gender: [ ] M [ ] F

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

2. Name of Dependent (last, first, middle initial): \_\_\_\_\_ Gender: [ ] M [ ] F

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

3. Name of Dependent (last, first, middle initial): \_\_\_\_\_ Gender: [ ] M [ ] F

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

4. Name of Dependent (last, first, middle initial): \_\_\_\_\_ Gender: [ ] M [ ] F

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Relationship: \_\_\_\_\_

[ ] Additional Dependent(s): check if applicable, and list information on a separate sheet of paper and attach to this form.

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**EMPLOYEE (Member) AGREEMENT**

By signing this form, I hereby enroll in the UCC Dental Benefits. If my status or my dependent’s status changes, I agree to notify the Pension Boards immediately.

Participant’s Signature \_\_\_\_\_ Date: \_\_\_\_\_

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**EMPLOYER AGREEMENT**

Employer signature is not required for self-pay Dental Benefits.

Employer signature is required if employee is eligible for UCC Dental Benefits or any insurance benefit offered by PBUC.

If you are a new Employer to the Pension Boards, you must complete a Qualified Church-Controlled Organization (QCCO) form and submit it to the Pension Boards at the address listed below or attach the form to the application for enrollment.

By signing this form, the Employer, by its duly authorized officer or other representative, hereby agrees to the provisions, rules, and procedures with respect to eligibility and contributions as indicated on this application, and in alignment with the Employer Adoption Agreement.

Employer ID: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Signature of authorized officer: \_\_\_\_\_ Date: \_\_\_\_\_

Please return this signed and completed form by email to: [info@pbucc.org](mailto:info@pbucc.org); by fax: 212.729.2701; or mail to: Pension Boards-UCC, 475 Riverside Drive, Suite 1020, New York, NY 10115.