



# UCC Medicare Advantage Plan with Rx and Dental Benefits Plan 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.

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## 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

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## EMPLOYEE INFORMATION

Employee Type: [ ] Clergy [ ] Lay For Clergy Only - Ordination Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Employment Type: [ ] Actively Working [ ] Retiree Date of Hire: \_\_\_\_/\_\_\_\_/\_\_\_\_

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## MEDICARE PARTICIPATION

What plan are you enrolled in? Medicare Part A [ ] Yes [ ] No Medicare Part B [ ] Yes [ ] No  
What plan is your spouse enrolled in? Medicare Part A [ ] Yes [ ] No Medicare Part B [ ] Yes [ ] No

**Note: A copy of your or your spouse's Medicare card(s) must be submitted with this application.**

## PLAN(S) ELECTED

Medical: [ ] Medicare Advantage Plan  
Dental: [ ] Dental Plan

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## DEPENDENT(S) INFORMATION

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 Medicare Advantage Plan with Rx and/or the Dental Benefits Plan as indicated above. If my status or my dependent's status changes, I agree to notify the Pension Boards immediately.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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## EMPLOYER INFORMATION

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

Employer signature is required if employee or dependent(s) is eligible for UCC Medicare Advantage Plan with Rx Plan. Contributions are to be paid by the employer. If the employer employs less than 20 employees, then a Small Employer Exemption form must be completed and submitted with this application to participate in the UCC Medicare Advantage Plan with Rx Plan.

Employer signature is required if employee is eligible for UCC Medical Benefits for non-Medicare eligible or any insurance benefit offered by PBUCC.

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.