The Pension Boards
United Church of Christ, Inc.
WHERE FAITH AND FINANCE INTERSECT

Health Benefit Dependent Change Form

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. Only complete the section(s) of the form that are being changed or updated. 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: _____/_____/_____

[ ] Add spouse / partner as health benefit dependent

DEPENDENT INFORMATION FOR INSURANCE – If you are applying for Medical and Dental Benefits, Dependent Information is required for enrollment.

UCC NON- MEDICARE PLAN STATEMENT OF HEALTH REQUIREMENTS **Current participants may apply for dependent coverage within the dependent's initial 90-days of eligibility. A Medical Statement of Health Form is required for applications received past initial eligibility periods. If applicable, please return a completed Medical Statement of Health form along with this form.

1. Coverage: [ ] Medical [ ] Dental

Name (last, first, middle initial): _____Relationship to participant: _____

SSN: _____Date of Birth: _____/ _____/ _____Gender: [ ] M [ ] F

2. Coverage: [ ] Medical [ ] Dental

Name (last, first, middle initial): _____Relationship to participant: _____

SSN: _____Date of Birth: _____/ _____/ _____Gender: [ ] M [ ] F

3. Coverage: [ ] Medical [ ] Dental

Name (last, first, middle initial): _____Relationship to participant: _____

SSN: _____Date of Birth: _____/ _____/ _____Gender: [ ] M [ ] F

4. Coverage: [ ] Medical [ ] Dental

Name (last, first, middle initial): _____Relationship to participant: _____

SSN: _____Date of Birth: _____/ _____/ _____Gender: [ ] M [ ] F

[ ] Additional Dependent Information for Insurance: Check if applicable, and list information on a separate sheet of paper and attach to this form.

EMPLOYER AGREEMENT

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 (SEE) form must be completed and submitted with this application to participate in the UCC Medicare Advantage Plan with Rx Plan.

[ ] Statement of Health: I understand that dependent applications for the UCC Non-Medicare Medical Plan require a medical Statement of Health form, if submitted after an initial 90-day UCC plan eligibility period. Dependents who previously opted out of plan enrollment during prior UCC eligibility, for any reason, may be required to submit a Statement of Health form. Additional Statement of Health criteria includes but is not limited to, lapses in coverage, returning to the plan after disenrolling and adding dependents after eligibility periods.

[ ] I certify that dependents listed are eligible to enroll in an employer-sponsored health plan. If my status or my dependent's status changes, I agree to notify the Pension Boards immediately.

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 Name: _____

Employer Address: _____City_____State _____ZIP_____

Signature of authorized officer: _____Date: _____/_____/_____

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