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

Annuity Plan Membership and Benefit Plans

EMPLOYER ID: _____ [ ] NEW EMPLOYER
MEMBER ID: _____ [ ] EXISTING MEMBER

By completing and submitting this form, I hereby apply for membership in the Annuity Plan for the United Church of Christ, in accordance with its Provisions, Rules and Procedures.

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 Date Employment Commenced: _____/_____/_____

Employment Type: [ ] Full Time [ ] Part Time [ ] Contract Average Hours Worked Per Week: _____

For Clergy Only - Ordination Date: ____ / ____ / _____ Conference: _____ Self Employed: [ ] Y [ ] N

OPTIONAL BENEFIT PLANS

Information about our additional plans are available online. *You are required to apply for plan additions within 90 days after date of hire. After 90 days, you are required to complete a Statement of Health form. Please select one option in each plan:

[ ] Medical* [ ] Plan A [ ] Plan B [ ] Plan C [ ] HSA

[ ] Dental* [ ] Dental Plan 2000 (with medical selected) [ ] Dental Plan 2000 Standalone (only if no medical is selected)

[ ] LIDI* Is this your first UCC employment in which you are working at least 20 hours per week? __ Yes or __ No

[ ] Basic Life Insurance

[ ] Vision Vision Plan premiums are payable at time of enrollment.

[ ] Single Adult $ 100 [ ] Two Adults $183

[ ] One Adult with Child(ren) $ 164 [ ] Two Adults with Child(ren) $249

[ ] Flexible Spending Benefit Plan - New members can enroll within the first 30 days of their employment. Existing members can enroll during the election period held at the end of the calendar year, for the following year.

[ ] I elect Medical Reimbursement [ ] I elect Dependent Reimbursement

Salary reduction: $_____ Medical $_____ Dependent

[ ] My health coverage is through my spouse's/partner's UCC Health Plan.

_____

Name of spouse/partner

COMPENSATION/SALARY INFORMATION

Salary Effective Date: ____ / ____ / _____ Date Approved by Church: ____ / ____ / _____

Cash Salary: $ _____

Housing Allowance: $ _____

Total Cash plus Housing Allowance: $ _____

Please note: Any changes to salary will be entered on the first day of the month following the Salary Effective Date.

PENSION DUES CONTRIBUTION

It is my present intention and that of my employer to make the following pension dues payments to the Annuity Plan.

Employer contributions: _____% or $_____ Effective Date: ____ / ____ / _____

Employee Pre-taxed salary reduction contributions: _____% or $_____ Effective Date: ____ / ____ / _____

Employee After tax dollars reduction contribution: _____% or $_____ Effective Date: ____ / ____ / _____

Please note: Any changes to contribution amounts will be entered on the first day of the month following the Effective Date.

INVESTMENT ALLOCATIONS

Information about our funds are available online.

		Sustainable Balanced Fund	Bond Fund	Equity Fund	Stable Value Fund	Global Sustainability Index Fund	TAD Fund 2025	TAD Fund 2030	TAD Fund 2035	TAD Fund 2040	TAD Fund 2045	TAD Fund 2050	**Fund percentage must total 100%**
Allocation of Future Contributions (5% increments)													
1	Employer Contributions	%	%	%	%	%	%	%	%	%	%	%	Total: _____%
2	Employee TSA and After-Tax	%	%	%	%	%	%	%	%	%	%	%	Total: _____%

After this pension account is established, you will receive a seven-digit Member ID number indicated in your enrollment letter. Your Member ID may be used on any correspondence sent to the Pension Boards. It may also be used to access the Member Portal on our website at www.pbucc.org. If you do not elect a beneficiary, your Estate will be the primary

beneficiary. If you do not indicate your desired allocations, any contributions made on your behalf will be invested in the Target Annuitization Date (TAD) Fund most appropriate to your anticipated retirement timeline based on your age.

DEPENDENT INFORMATION FOR INSURANCE

Coverage: [ ] Medical [ ] Dental [ ] Vision

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

SSN: _____ Date of Birth: ____ / ____ / _____ Gender: [ ] M [ ] F

Coverage: [ ] Medical [ ] Dental [ ] Vision

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

SSN: _____ Date of Birth: ____ / ____ / _____ Gender: [ ] M [ ] F

Coverage: [ ] Medical [ ] Dental [ ] Vision

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

SSN: _____ Date of Birth: ____ / ____ / _____ Gender: [ ] M [ ] F

(Please note: If you have additional dependents to add, please list dependents on a separate piece of paper, including all the above information, and attach to this form upon submission.)

BENEFICIARY INFORMATION:

Beneficiary(ies): I hereby designate the following as Primary or Secondary Beneficiary(ies). If more than one is designated, each surviving Beneficiary shall receive the percentage share indicated. Please note, if you designate a minor as a beneficiary, you are required to have a probate court-appointed guardian to receive and administer the death benefits to the minor. Do not write the name of the guardian on this form.

Total proportion of designations must total 100%.

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

SSN: _____ Date of Birth: ____ / ____ / _____ Gender: [ ] M [ ] F

Annuity: [ ] Primary _____% [ ] Secondary _____ %

Life Insurance: [ ] Primary _____% [ ] Secondary _____ %

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

SSN: _____ Date of Birth: ____ / ____ / _____ Gender: [ ] M [ ] F

Annuity: [ ] Primary _____% [ ] Secondary _____ %

Life Insurance: [ ] Primary _____% [ ] Secondary _____ %

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

SSN: _____ Date of Birth: _____ / ____ / _____ Gender: [ ] M [ ] F

Annuity: [ ] Primary _____% [ ] Secondary _____ %

Life Insurance: [ ] Primary _____% [ ] Secondary _____ %

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

SSN: _____ Date of Birth: ____ / ____ / _____ Gender: [ ] M [ ] F

Annuity: [ ] Primary _____% [ ] Secondary _____ %

Life Insurance: [ ] Primary _____% [ ] Secondary _____ %

EMPLOYEE / EMPLOYER AGREEMENT

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.

As an eligible employee in the Flexible Benefit Plan for UCC Ministries, I acknowledge that I have read the Highlights Brochure and understand the benefits available to me as well as the other rights and obligations which I have under the Plan.

[ ] 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.

[ ] I have attached a copy of my birth certificate. If I cannot supply a birth certificate, I have attached a copy of my passport or driver's license.

Employee Signature: _____ Date: ____ / ____ / _____

Witness's Signature (not a beneficiary): _____ Date: ____ / ____ / _____

SPOUSAL CONSENT

Spousal consent is required if the applicant is married and has not designated their spouse as the sole beneficiary. Please note: A notary is also required if the spouse is signing the form.

Spouse's Consent:
[ ] I hereby consent to the above beneficiary(ies) designated by my spouse.

Spouse's Signature _____ Date: ____ / ____ / _____

NOTARY

(Please note: A notary is only required if the spouse is signing the form.)

Notary's Signature _____ Date: ____ / ____ / _____

Notary's Stamp:

Employer Name: _____

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.