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

Annuity Plan Membership and Other Benefit Plans

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

***If you are an existing member, 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: _____/_____/_____

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

COMPENSATION/SALARY INFORMATION

Salary Effective Date: ____ / ____ / _____

Base Salary: $ _____

Housing Allowance: $ _____

Total Base Salary plus Housing Allowance: $ _____

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

OPTIONAL BENEFIT PLANS

Information about our additional plans are available online.

Please select one or more options:

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

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 for enrollment into Medicare Advantage Plan.

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

[ ] LIFE INSRUANCE AND DISABILITY INCOME BENEFITS**

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

[ ] Basic Life Insurance ***
[ ] Optional Additional Life ***
[ ] Optional Additional Dependent Spouse***
[ ] Optional Additional Dependent Child***

******Participants are required to apply for plan within 90 days of date of hire. The UCC Medicare Advantage Plan with Rx does not require a Statement of Health form. After 90 days of hire, you are required to complete a Medical Statement of Health form. Participants applying for Life and Disability Income Benefits after 90 days of date of hire, are required to complete a MetLife Statement of Health form.

*******You must also complete the attached MetLife Enrollment form and return it with this enrollment application.

[ ] FLEXIBLE SPENDING ACCOUNT (FSA): - 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

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

DEPENDENT INFORMATION FOR INSURANCE, continued

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

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

PENSION CONTRIBUTIONS

It is my present intention and that of my employer to make the following pension dues payments to the Annuity Plan. All deductions are on a payroll frequency.

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

Employee Pre-Tax Salary Reduction**** _____% or $_____ Effective Date: ____ / ____ / _____

Employee After-Tax Salary Reduction**** _____% or $_____ Effective Date: ____ / ____ / _____

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

******PAYROLL DEDUCTIONS FREQUENCY**

[ ] Monthly (12 paychecks per year) [ ] Twice monthly (24 paychecks per year)
[ ] Bi-Weekly (26 paychecks per year) [ ] Weekly (52 paychecks per year)

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 Contributions	%	%	%	%	%	%	%	%	%	%	%	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.

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%.

SSN: _____ Name (last, first, middle initial): _____

Address Line 1: _____

Address Line 2: _____

Address Line 3. _____ [ ] Domestic [ ] Foreign

City _____ State _____ Zip Code _____

Relationship to participant: _____ Date of Birth: ____ / ____ / _____ Gender: [ ] M [ ] F

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

SSN: _____ Name (last, first, middle initial): _____

Address Line 1: _____

Address Line 2: _____

Address Line 3. _____ [ ] Domestic [ ] Foreign

City _____ State _____ Zip Code _____

Relationship to participant: _____ Date of Birth: ____ / ____ / _____ Gender: [ ] M [ ] F

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

[ ] Additional Primary and Secondary Beneficiary(ies): Check if applicable, and list information on a separate sheet of paper and attach to this form.

EMPLOYEE (Member) 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.

EMPLOYEE (Member) AGREEMENT, continued

[ ] I understand that the amount of such reduction, pursuant to this election, will be withheld from my pay on a pre-tax and/or after-tax basis, as specified above, and will be paid by my employer into my account in the Annuity Plan.

I understand: (1) my election regarding elective deferrals is irrevocable once the employer withholds the deferrals from my pay; and (2) any changes in elective deferrals is effective only for deferrals from pay I received after the plan administrator accepts my change of election.

I understand that written notice must be given before the effective date of any modification. This election will remain in effective until I revoke complete a new Employee Pre-Tax Retirement Contribution Agreement.

[ ] I have completed the MetLife Enrollment form for Life Insurance and Disability Income Benefits form.

[ ] I have completed and attached the Annuity Plan Member and/or Beneficiary Acknowledgment Form.

[ ] 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. **(THIS APPLIES TO FIRST-TIME ENROLLMENTS ONLY.)**

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.

Employee (Member) Signature: _____ Date: ____ / ____ / _____

Required if Participating in the Annuity Benefits Plan.
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 AGREEMENT

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

Employer signature is required if participant 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.

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.

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.

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.