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

Termination of Benefits Form

This form should be used to process benefit terminations for terminated employees, remove dependents, or cancellation of benefits.

Employer ID: _____
Member ID: _____

Self-Pay: [ ] check if applicable

EMPLOYEE PERSONAL INFORMATION

Name of Member (last name, first name): _____

Address: _____ City_____ State _____ ZIP_____

Cell Phone: (____) _____ - _____ Home Phone: (____) _____ - _____ Email: _____

Is the member an Interim Minister? [ ] Yes or [ ] No
Does the member participate in Association of UCC Interim Minsters (AUCCIM)? [ ] Yes [ ] No
Is the member continuing employment with another church? [ ] Yes [ ] No [ ] Unknown

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TERMINATION OF BENEFITS

Please enter the last day of the last month, of which the member should receive benefits. You may opt out of one or multiple benefits using this form.

[ ] Medical	Term Date: _____/_____/_____	[ ] Dental	Term Date: _____/_____/_____
[ ] Life Insurance/Disability	Term Date: _____/_____/_____	[ ] Flexible Spending Plan	Term Date: _____/_____/_____
[ ] Annuity *Employer Contributions*	Term Date: _____/_____/_____	[ ] Annuity *Personal Contributions*	Term Date: _____/_____/_____
[ ] Vision	Term Date: _____/_____/_____		

**Vision benefits will terminate at the end of the current plan year (March 31st).*

DEPENDENT INFORMATION

List any dependents that should be removed from coverage.

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

[ ] **Additional Dependent Information:** Check if applicable then list the additional information on a separate document and attach to this form.

TERMINATION OF EMPLOYMENT

List the official last date of employment, if applicable:

____/_____/_____

Please note that the employee is eligible to continue Medical, Dental, Life Insurance (eligible to continue for age 55 and older) and Vision benefits on a self-paid basis. The employee will be sent the Continuation of Benefits form upon termination of employment.

EMPLOYER VERIFICATION

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: _____

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. 11/2022

SELF-PAY MEMBER CONSENT

[ ] By signing this form, I 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.

Member Name: _____

Member Signature:_____ 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.