

UCC Medical and Dental Benefits Enrollment Application

PARTICIPANT INFORMATION								
Social Security Number	Name of em	e of employee (last, first, middle initial)						
Address (number and street)		City/S	City/State/ZIP					
Telephone number (with area code)		E-mail	E-mail address					
() –			@					
Relationship Status:	Title:	Do you	Do you or any member of your family have other Is this your first			our first		
□ Single □ Widowed	☐ Ms. ☐ Mr.		medical or dental coverage? UCC employment			mployment?		
□ Married □ Civil Union	\Box Rev. \Box Dr.	□ Yes						
□ Divorced □ Domestic Partnership		If yes, lis	st carrier name:					
Ordination Date (<i>if applicable</i>):	Date of Marriage	or Domes	• Domestic Partnership (only if enrolling spouse/partner):					
PLAN(S) ELECTED:								
Selected Medical Plan Option (check one only): Plan A Plan B Plan C HSA Plan C HSA DENTAL Selected Dental Plan Option (check one only): Dental 2000 Plan Standalone Dental (only if no Medical is elected)								
PROVIDE EMPLOYEE AND DEPENDENT(S) INFORMATION BELOW								
			heet if necessary)		1	0 1		
Name	Relation	-	Date of birth	Social Security Num	nber	Gender		
(last, first, middle initial)	partici Sel		-		7			
				XXX-XX-XXXX	x			
	Spouse/I	Partner						
Employee: Please read and sign below. (Unsigned applications will be returned.) If my status or my dependent's status changes, I agree to notify the Pension Boards immediately. I hereby enroll in the UCC Medical and Dental Benefits Plan as indicated above.								
SIGNATURE								
Employee signature		Date						

EMPLOYER INFORMATION							
Name of employer							
	1						
Employer ID #	Date of hire	Hours worked	per week				
Address (number and street)	City/State/ZIP	City/State/ZIP					
Employer Signature	Da	ate signed					

INSTRUCTIONS

Please complete all required information and sign your enrollment application. Any incomplete, unsigned application will be returned and not accepted by the Pension Boards.

Eligible employees must enroll in the UCC Medical Benefits Plan within 90 days of initial UCC employment. Late applicants will need to provide a completed Statement of Health form for themselves and each dependent applying for coverage. This form is available on our website at **www.pbucc.org**.

Eligible employees must enroll in the UCC Dental Benefits Plan within 90 days of initial UCC employment. Late applicants will need to apply for the UCC Dental 750 Plan during the annual open enrollment held in October of each year. Benefits will then begin on January 1 of the next Plan Year. This form is available on our website at **www.pbucc.org**.

"Dependent(s)" includes the spouse or domestic partner and children.

Please be sure to list all dependents to be covered under your policy with the UCC Medical and Dental Benefits Plan. Use an additional sheet of paper if necessary.

Employer Signature is required if UCC Medical and Dental Benefits Plan contributions are to be paid by the employer.

QUESTIONS? NEED ASSISTANCE?

The Pension Boards staff is available to assist you in this important process. Please feel free to contact a Member Services Representative toll-free at **1.800.642.6543** or by e-mail at **info@pbucc.org**.

Please return completed form to the Pension Boards via fax at 212.729.2701 or email at info@pbucc.org Please retain a copy for your records.

