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 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: _____/_____/_____

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

Date of Hire: _____/_____/_____

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 **Effective Date** _____/_____/_____
[ ] UCC Medicare Advantage Plan with Rx

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 the UCC Medicare Advantage Plan with Rx.

[ ] DENTAL [ ] Dental Plan (with medical selected) **Effective Date** _____/_____/_____
[ ] Dental Plan Standalone (only if no medical is selected)

Participants may apply for medical plan coverage within 90 days of date of hire. After 90 days of hire, you are required to complete a Medical Statement of Health form. Please click here **https://bit.ly/PB_SOH to download a Statement of Health form. Participants applying for Life and Disability Income Benefits after 90 days of initial date of hire, are required to complete a MetLife Statement of Health form. Please visit **https://bit.ly/MET_SOH** to download a MetLife Statement of Health form. The UCC Medicare Advantage Plan with Rx does not require a Statement of Health form. The completed statement of health form(s) must be returned along with your Annuity Plan Membership and Other Benefits Form.

[ ] LIFE INSURANCE AND DISABILITY INCOME BENEFITS** **Effective Date** _____/_____/_____
Is this your **initial** 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***

*** **For Life Insurance and Disability only:** You may click here **https://bit.ly/METLIFE_CHANGE** to print out the Life Insurance and Disability Income (LIDI) MetLife Enrollment Change Form. The completed MetLife Form needs to be returned along with your Annuity Plan Membership and Other Benefits Form.

[ ] 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.

Effective Date _____/_____/_____

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

Salary reduction: $_____ Medical $_____ Dependent
(2021 IRS Max=$2,750) ***(2021 IRS Max=$5,000)***

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

_____
Name of spouse/partner

DEPENDENT INFORMATION FOR INSURANCE

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.

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.

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

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

EMPLOYEE RETIREMENT CONTRIBUTIONS

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

Employee After-Tax Salary Reduction****_____ % or $_____ 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%**
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. **Total proportion of designations must total 100%.** 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. You must submit a complete copy of the Trust.

1. 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 _____ %

2. 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 a Member (as defined in the Annuity Plan document), together with my designated Beneficiary or Beneficiaries (as defined in the Annuity Plan document), I acknowledge that the Annuity Plan document is available to me on the **Pension Boards website** (www.pbucc.org) or by clicking here**: https://bit.ly/ANNUITY_PLAN**. In addition, I acknowledge that I and my Beneficiary shall, at all times, be subject to the terms and conditions of the Annuity Plan document, as the same may be amended, modified, or supplemented at the sole discretion of The Pension Boards–United Church of Christ, Inc.

[ ] I understand: (1) my election regarding elective deferrals is irrevocable once the employer withholds the deferrals from my pay; (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 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; and (3) 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 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 ANNUITY FUND MEMBERSHIP ENROLLMENTS ONLY.)**

[ ] As an eligible employee in the Flexible Benefit Plan for UCC Ministries, I understand that I should review the Highlights of Your Flexible Benefit Plan for UCC Ministries or by clicking here: **https://bit.ly/PB_FSA_BKLT** to 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 completed the MetLife Enrollment form for Life Insurance and Disability Income Benefits form.

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 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. Please click here **https://bit.ly/PB_SEE_FORM** for the Small Employer Exemption form.

Employer signature is required if employee is eligible for UCC Medical Benefits for Non-Medicare eligible, or any insurance benefit offered by PBUCC.

Employers enrolling in Flexible Spending Account Benefits for the **first time only** must visit our website **www.pbucc.org** or click here: **https://bit.ly/FSA_ADOPT** to download and complete an Adoption Resolution for the Flexible Benefit Plan for UCC Ministries. The agreement and application must include a $100 start-up fee.

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 of attach the form to the application for enrollment.

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.