THE BOARD OF PENSIONS
OF THE PRESBYTERIAN CHURCH (U.S.A.)

Please print, complete, and mail, fax, or email this form to the Board of Pensions.

Use this form to report a service change and make benefit elections for members. Please report this change within 30 days of the change.

If the member is serving multiple PINs, each church or employing organization remitting benefits dues must complete a separate Service Change form (ENR-110).

Member Information

Check One: ☐ Dr. ☐ Miss ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Rev. *(teaching elder members must use Dr. or Rev.)*

Name SSN

Address

City State ZIP

Select one number as preferred

☐ Daytime Phone ( ) ☐ Home Phone ( ) ☐ Cell Phone ( )

Primary Email Secondary Email

☐ Check here if your covered partner is also enrolled under the Benefits Plan as a result of her/his employment for Traditional Program coverage, not the Affiliated Benefits Program.

☐ I checked the above box and my covered partner and I are both ordained teaching elders, called to pastoral relationships at the same church and each of us is employed for fewer than 35 hours per week.

Service Information

Effective date of service *(mm/dd/yyyy)*

Church/organization name PIN

Address

City State ZIP

Phone ( ) Fax ( ) Primary Email

Position title ___________________________________ Ordained position code from GA Minutes Book ______________

Employment Classification: ☐ Exempt lay member* ☐ Non-exempt lay member* ☐ Ordained

Date ordained or received into PC(USA) ____

For plan participation, full time is 35 hours or more per week. Number of scheduled hours per week (excluding overtime):

☐ **Part-time/20-34 hours** If checked, write actual hours ________________ ☐ **Full-time/35 hours or greater**

** Visit the Department of Labor website, dol.gov, for classification information.*

Annual Salary Information

Please enter annual amounts or zero if not applicable. You may use the total effective salary calculator and the dues calculator on pensions.org to determine the impact the reported effective salary has on dues.

Effective salary is any compensation a member receives during a plan year from an employing organization. For more information, see the Understanding Effective Salary booklet, available on pensions.org.

1. Cash salary *(including employee contributions to 403(b)(9) plans; tax-sheltered annuity plans; unvouchered book, car, and study allowances; vacation pay and overtime)* 1. $__________
2. Housing allowance, utilities, and furnishings allowances 2. $__________
3. Employing organization contributions to 403(b)(9) plans, tax-sheltered annuity plans, and equity allowances *(matching contributions to the Board's Retirement Savings Plan should not be included)* 3. $__________
4. Bonus *(will be included in the year in which the bonus is paid; dues will be billed on a lump-sum basis)* 4. $__________

   Year in which bonus is paid ______________________
5. SECA *(for reimbursement in excess of 50% of the teaching elder's SECA tax obligation)* 5. $__________
6. Other allowances *(including copayment and medical expense reimbursement allowances)* 6. $__________

   Do not include expenses reimbursed through vouchers or Benefits Plan dues.
7. Manse amount *(must be at least 30% of lines 1-6 for members residing in a manse)* 7. $__________
8. **Total Annual Effective Salary** ***(total of lines 1-7)*** 8. $__________

Dues are computed and benefits are determined on this amount (subject to minimums and maximums).

Selection of Coverage

Please check one:

☐ Full Participation – Medical, pension, death, and disability benefits. Mandated for teaching elders serving churches in installed positions.

☐ Limited Participation - Medical, death, and disability.

Select Medical Coverage Level – *Check one*

☐ Member-only

☐ Member + spouse

☐ Member + child(ren)

☐ Member + family

If the member and his/her spouse are a Member Couple with Child(ren), will this employing organization be remitting dues for family medical coverage? ☐ Yes ☐ No

Waiver of Medical Coverage for Eligible Family Members

If you are waiving medical coverage for your member's eligible family members, you must certify that your employing organization has the Eligible Family Member Coverage Waiver form (ENR-009) for this member's eligible family members on file. Please check below to indicate that you are certifying an Eligible Family Member Coverage Waiver form is on file.

☐ **Waiver on file**. By checking this box, I certify that the employer has the Eligible Family Member Coverage Waiver form on file for this member's eligible family members.

HMO Option

This option is available only to members who work or reside in the Mid-Kentucky Presbytery. Would you like to receive information on participating in an HMO? ☐ Yes ☐ No

Optional Benefits

Members starting in a new service immediately after terminating a prior service can elect optional benefits. Your employing organization will be billed for all optional benefit elections.

Dental Benefits

☐ Member had optional dental coverage at previous employer or under transitional participation coverage and would like to continue the same level of coverage. Please note that if the member has moved and coverage options have changed as a result, an application will be mailed to the member with available options. If the current dental option is not available, a new application must be submitted to elect other coverage. The member can call the Board at 800-773-7752 (800-PRESPLAN) with the new postal code or visit pensions.org for the available options.

☐ The member did not have optional dental coverage at previous employer but would like to consider enrollment. The member should visit pensions.org for the available options and information.

☐ The member had dental coverage at previous employment or under transitional participation coverage but does not wish to continue at this time.

☐ The member did not have dental coverage and is not interested at this time. The member understands that he/she will only be able to enroll if there is a qualifying life event or if there is an annual enrollment period and that there may be a 12-month limitation on certain dental services.

Optional Supplemental Death Benefits

☐ The member had supplemental death benefits at previous employment or under transitional participation coverage and would like to continue the same level of coverage.

☐ The member did not have supplemental death benefits at prior service but would like to consider enrollment.

☐ The member had supplemental death benefits at prior service but does not wish to continue at this time.

☐ The member did not have supplemental death benefits at prior service and is not interested at this time.

Optional Retirement Savings Plan

- A member must complete a new Retirement Savings Plan Salary Deferral Agreement form (ORS-001) to elect to participate or to continue participation in the Retirement Savings Plan.

Eligible Family Members *(Only if there is a change)*

List each eligible family member for whom the change applies (attach a separate sheet of paper if necessary). Documentation is required regardless of the plan(s) in which the eligible family member is enrolled.

Make certain to submit the required documentation if not previously submitted. The changes will not be processed without the required documentation.

* If the eligible family member is to be added to dental or supplemental death benefits coverage, the member should go to pensions.org to learn about eligibility, coverage, limitations, and costs and to complete and submit the appropriate application form.

☐ **Add** ☐ **Drop**

Spouse's Name* SSN

Birth Date *(mm/dd/yyyy)* Gender ☐ M ☐ F

* Include a copy of the official documentation issued by a state or a foreign jurisdiction.

Check benefit(s) for which family member is to be enrolled: ☐ Medical ☐ Dental* ☐ Supplemental Death*

Is this family member enrolled in Medicare Part A or B? ☐ Yes ☐ No

Address *(if different from the member's address)*

City State ZIP

Please list all children, including all non-custodial children, up to age 26. Include a copy of the birth certificate or legal documentation for each child listed, if not previously submitted.

☐ **Add** ☐ **Drop**

Child's Name SSN

Birth Date *(mm/dd/yyyy)* Disabled ☐ Yes ☐ No Gender ☐ M ☐ F

Check benefit(s) for which family member is to be enrolled: ☐ Medical ☐ Dental* ☐ Supplemental Death*

Is this family member enrolled in Medicare Part A or B? ☐ Yes ☐ No Is child a legal ward? ☐ Yes ☐ No

Address *(if different from the member's address)*

City State ZIP

☐ **Add** ☐ **Drop**

Child's Name SSN

Birth Date *(mm/dd/yyyy)* Disabled ☐ Yes ☐ No Gender ☐ M ☐ F

Check benefit(s) for which family member is to be enrolled: ☐ Medical ☐ Dental* ☐ Supplemental Death*

Is this family member enrolled in Medicare Part A or B? ☐ Yes ☐ No Is child a legal ward? ☐ Yes ☐ No

Address *(if different from the member's address)*

City State ZIP

Authorization

Member Authorization

I certify that the information on this form is complete and accurate.

Member signature *(required)* Date *(mm/dd/yyyy)*

Employing organization authorization - On behalf of the employing organization, I certify that we have confirmed eligibility for plan benefits for spouse and the children as defined by the Benefits Plan of the Presbyterian Church (U.S.A.). I confirm the accuracy of the information concerning benefits selection, and that the employing organization agrees to pay all required dues for medical, pension, and death and disability or, for a leave of absence, that the member intends to return to work at the same organization and has not been terminated. The authorized representative may be the treasurer, clerk of session, business manager, or financial secretary.

If I am waiving medical coverage for any member's eligible family members, I certify that my employing organization has the Eligible Family Member Coverage Waiver form (ENR-009) for this member's eligible family members on file. I have completed the appropriate information in the Selection of Coverage part of this form.

Authorized representative name *(required)*

Official capacity Daytime phone ( )

Signature *(required)* Date *(mm/dd/yyyy)*

Please visit pensions.org or call the Board at 800-773-7752 (800-PRESPLAN) for information or publications.

Mail, fax, or email this completed form to: The Board of Pensions of the Presbyterian Church (U.S.A.)
2000 Market Street, Philadelphia, PA 19103-3298
800-773-7752 (800-PRESPLAN) Fax: 215-587-6215 Email: memberservices@pensions.org