The Board of Pensions
of the Presbyterian Church (U.S.A.)

MED-100
Rev. 01/14

Medical Continuation Subscription or Waiver

Before completing this form, please read the Medical Continuation Benefits Overview (PTS-604) or the Medical Continuation for Retiring Members before Age 65. Benefits Overview (PTS-605), as appropriate, for eligibility requirements, *including a definition of the Rule of 70*, waiver implications, and other important information. (These forms are available at pensions.org or by calling the Board of Pensions.) Your eligibility for continuing medical benefits will be reviewed upon receipt of this completed form.

Instructions: To *enroll* in Medical Continuation coverage, complete Sections A, B, and C. To waive Medical Continuation coverage, complete Sections A and D.

A Subscriber's Personal Information

Subscriber's name *(first, middle, last)* SSN

Address

City State ZIP

( ) ( )
Daytime phone Cell phone Primary email

If you are not the member, please complete:

Member's name *(first, middle, last)* SSN

Please note: All written communication will be sent to your home address, listed above, unless a mailing address is on file. If you wish to add or maintain a mailing address, please complete the mailing address section below:

Mailing address

Address

City State ZIP

Note: If your address has changed or will soon change, please complete and submit an Address and Contact Information Change form (ENR-106).

B Subscription

I want to subscribe for Medical Continuation coverage as a *(check one)*:

☐ Member retiring before age 65 ☐ Terminated (inactive) member ☐ Covered partner ☐ Surviving covered partner
☐ Former covered partner ☐ Child ☐ Former child

I want to participate in *(check one)*: ☐ Traditional coverage, Medical Plan PC(USA) ☐ HMO (Mid-Kentucky Presbytery only)

I wish to enroll the following eligible family members, including myself:

Name *(first, middle, last)*	Birth date	Relationship	SSN
Name *(first, middle, last)*	Birth date	Relationship	SSN
Name *(first, middle, last)*	Birth date	Relationship	SSN
Name *(first, middle, last)*	Birth date	Relationship	SSN

Use a separate sheet if necessary.

C Subscription Authorization

I elect to subscribe for the Medical Continuation Program as described in the Benefits Plan of the Presbyterian Church (U.S.A.) (Article XIII. Section 13.15 or Article XIV, Section 14.1).

I authorize the Board of Pensions to deduct subscription charges from my pension benefit check. If I am not receiving a pension benefit or the payment amount does not cover the monthly cost of the subscription, I agree to pay the dues and authorize the Board of Pensions to bill me monthly, in advance, for this coverage.

Method of Payment *(check one)*:

☐ I wish to have deductions made from my pension check for the full cost of this coverage.

☐ I have enclosed a check to pay for the cost of this coverage through the current month plus one month in advance. *If you wish to have future monthly payments deducted from your bank account via BoardLink®*, visit pensions.org or call 800-773-7752 (800-PRESPLAN) for more information.

I understand that I may permanently terminate this subscription at any time by sending **advance** written notice to the Board of Pensions. Otherwise, my subscription will terminate on the date the request is received. If I fail to pay any subscription charge within 30 days of its due date, coverage is permanently terminated. I also understand that if I terminate my coverage, no re-election is possible at a later date.

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

Signature of covered partner *(if applicable)* Date *(mm/dd/yyyy)*

D Application and Authorization for Waiver of Coverage (complete only if waiving coverage)

I am applying for a waiver of Medical Continuation coverage under the Benefits Plan of the Presbyterian Church (U.S.A.) and certify that the member and/or covered partner's, former covered partner's, or surviving covered partner's medical coverage is a qualified health plan.

Name of member's qualified health plan

Name of covered partner's qualified health plan

☐ I wish to waive only my coverage now (member or former covered partner must sign below)

☐ We wish to waive only my covered partner's coverage now (both member and covered partner must sign below)

☐ We both wish to waive coverage now (both member and covered partner must sign below)

I/we understand and accept that:

- If the Board of Pensions approves this application, the Board will pay no medical benefits whatsoever for the above-named member and/or covered partner during the effective term of this waiver.
- The Board can reinstate Medical Continuation coverage for the member and/or covered partner only at the time of one of these qualifying events:
  - the death of the member and/or covered partner,
  - the involuntary loss of medical coverage,
  - retirement,
  - termination of employment
  - I decide within 12 months of waiver that the qualified health plan is not meeting my needs

We also understand that we must apply for coverage within 30 days of the qualifying event.

I/we hereby release the Board of Pensions from any and all liability resulting from relying and acting upon the information supplied on this waiver application.

Signature of member/subscriber *(required)* Date *(mm/dd/yyyy)*

Signature of covered partner *(if applicable)* Date *(mm/dd/yyyy)*

Mail or fax 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
pensions.org

Current and former Board of Pensions employees mail or fax this completed form to:

The Board of Pensions of the Presbyterian Church (U.S.A.)
Attn: Human Resources
2000 Market Street, Philadelphia, PA 19103-3298
215-587-7270 Fax: 215-587-7129 pensions.org