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

Benefits Plan Membership Application

SEMINARY STUDENT

The following must be submitted before your application is considered complete:

1. The first month's payment to activate coverage.
   [Please mail payment to The Board of Pensions of the Presbyterian Church (U.S.A.), 2000 Market Street, Philadelphia, PA 19103-3298.]
2. Written verification from your presbytery that you are an inquirer or a candidate for ordination.*
3. Written verification from your seminary that you are enrolled as a full-time student.*
4. A copy of supporting documentation to verify eligibility for each family member listed below
   (such as a marriage certificate, birth certificate, or letter of intent/decree for adoption).

* Required each year to maintain medical coverage

Applicant information

I am *(select one)*:

☐ an existing full-time seminary student, classified as an inquirer or candidate under the care of a presbytery, applying for seminarian healthcare coverage during **annual enrollment**.

☐ an existing full-time seminary student, classified as an inquirer or candidate under the care of a presbytery, applying for seminarian healthcare coverage **as a result of a life event**.

☐ a new full-time seminary student, classified as an inquirer or candidate under the care of a presbytery, applying for seminarian healthcare coverage **within 60 days of full-time seminary enrollment**.

☐ an existing full-time seminary student, under the care of a presbytery, applying for healthcare coverage **within 60 days of being classified as an inquirer/candidate**.

Anticipated date of graduation *(mm/dd/yyyy)*		
Name *(first, middle, last)*	SSN	
Birth date *(mm/dd/yyyy)*	Gender ☐ Female ☐ Male	
Marital status ☐ Single ☐ Married	Date of marriage *(mm/dd/yyyy)*	
Permanent address		
City	State	ZIP
Daytime phone	Email	
Mailing address *(if different from permanent address)*		
City	State	ZIP

Complete and email this form to the Board of Pensions at memberservices@pensions.org.
Questions? Call the Board at 800-773-7752 (800-PRESPLAN)

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Eligible family members		
Spouse's name		SSN
Birth date *(mm/dd/yyyy)*		Gender ☐ Female ☐ Male
Is this family member enrolled in Medicare Part A or B? ☐ Yes ☐ No		
Address *(if different from the applicant's address)*		
City	State	ZIP

List all children, up to age 26. Include a copy of the birth certificate or legal documentation for each child listed.

Child's name		SSN
Birth date *(mm/dd/yyyy)*	Disabled ☐ Yes ☐ No	Gender ☐ Female ☐ Male
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 applicant's address)*		
City	State	ZIP

Child's name		SSN
Birth date *(mm/dd/yyyy)*	Disabled ☐ Yes ☐ No	Gender ☐ Female ☐ Male
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 applicant's address)*		
City	State	ZIP

Child's name		SSN
Birth date *(mm/dd/yyyy)*	Disabled ☐ Yes ☐ No	Gender ☐ Female ☐ Male
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 applicant's address)*		
City	State	ZIP

Child's name		SSN
Birth date *(mm/dd/yyyy)*	Disabled ☐ Yes ☐ No	Gender ☐ Female ☐ Male
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 applicant's address)*		
City	State	ZIP

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Effective Date and Coverage Elections

Coverage for approved applications submitted during annual enrollment will begin September 1.

Coverage for approved applications submitted other than during annual enrollment will begin:

- the date of the event (e.g., new full-time student, new candidate or inquirer, or life event), if application is received in advance of the start date; or
- the first of the month following the Board's receipt of a completed application, provided the application is received within 60 days of the event.

Plan membership requested effective date:

☐ September 1 ☐ Other *(specify)* _____

Medical coverage *(check one)*

☐ PPO Medical ☐ EPO Medical ☐ HDHP Medical

Select Medical coverage level *(check one)*

☐ Member-only ☐ Member + Spouse ☐ Member + Child(ren) ☐ Member + Family

Authorization

I/We confirm that the information provided in this application is true, correct, and complete to the best of my/our knowledge. My/Our signature(s) certifies and confirms that my spouse and/or children are eligible for plan benefits as defined by the Benefits Plan of the Presbyterian Church (U.S.A.). If this information changes, I will immediately notify The Board of Pensions of the Presbyterian Church (U.S.A.). In accordance with the Benefits Plan, I agree to furnish any information the Board needs in connection with any medical claim for a family member or me, including information about any other group medical coverage.

I/We hereby consent to the release of my personal health information, and if applicable that of my/our children to the Board's representatives and agents, including without limitation, the Board's medical plan administrator and pharmacy benefit manager, their successors and assignees, for the purpose of paying claims and administering the Medical Plan.

I/We also understand that I/we will be billed for coverage a month in advance and must pay the bill for coverage to continue. If I/we do not pay for two consecutive months, I/we understand that coverage will be terminated without right of reinstatement.

Applicant's signature *(required)*	Date *(mm/dd/yyyy)*
Spouse's signature *(required)*	Date *(mm/dd/yyyy)*

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