The Pension Boards
United Church of Christ, Inc.
WHERE FAITH AND FINANCE INTERSECT

EE & BEN TERM

Termination of Benefits/Employment

Complete this form for terminations of employees, to remove dependents, or cancel benefits.

MEMBER ID: ☐☐☐☐ - ☐☐☐ Last 4 Digits of SSN: X X X - X X - ☐☐☐☐

PERSONAL INFORMATION

Member Name: Last_____, First_____, Initial_____

Address: _____City: _____

State: _____ Zip: __ __ __ __ __

Home Phone: (____) ____ - _____ Cell Phone: (____) ____ - _____ Email: _____

Gender: M **[ ]** F **[ ]** Date of Birth ____/_____/_____ Title: Rev. **[ ]** Dr. **[ ]**
MM DD YYYY

Relationship Status: Single **[ ]** Married **[ ]** Divorced **[ ]** Widowed **[ ]**

TERMINATION OF BENEFITS

Please enter the last day of the last month, of which the member should receive benefits. You may opt out of one or multiple benefits using this form.

[ ] Medical Term Date ____/_____/_____
MM DD YYYY

[ ] Dental Term Date ____/_____/_____
MM DD YYYY

[ ] Life Insurance/Disability Term Date ____/_____/_____
MM DD YYYY

[ ] Medical Reimbursement (FSA) Term Date ____/_____/_____
MM DD YYYY

[ ] Dependent Care Reimbursement Term Date ____/_____/_____
MM DD YYYY

[ ] Optional Life Insurance Term Date ____/_____/_____
MM DD YYYY

[ ] Annuity Employer Contributions Term Date ____/_____/_____
MM DD YYYY

[ ] Vision* Term Date ____/_____/_____
MM DD YYYY

***NOTE:** Vision benefits will terminate at the end of the current plan year (March 31st).

TERMINATION OF EMPLOYMENT

List the official last date of employment, if applicable:

Termination Date ____/_____/_____ Employer ID #: | | | | | |

MM DD YYYY

Please note that the employee is eligible to continue Medical, Dental, Life Insurance (eligible to continue for age 55 and older) and Vision benefits on a self-paid basis. The employee will be sent the Continuation of Benefits form upon termination of employment.

EMPLOYER VERIFICATION

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: _____

Name of authorized officer: _____
Please Print

Title of authorized officer: _____
Please Print

Signature of authorized officer: _____ Date: ____/_____/_____
MM DD YYYY

SELF-PAY MEMBER CONSENT

[ ] By signing this form, I hereby agree 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.

Employee Name: _____
Please Print

Signature of Employee: _____ Date: ____/_____/_____
MM DD YYYY

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.