RCA ENROLLMENT FORM

- PLEASE TYPE OR PRINT CLEARLY -

I. APPLICANT INFORMATION

Full Legal Name ____
(first, middle, last/family name)

Title Preference: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Rev. ☐ Dr. ☐ Chap. ☐ None

Social Insurance Number __ __ __-__ __ __- __ __ __ Date of Birth _______/_______/_______ Gender: ☐ M ☐ F

Home Address ____

City ____________________ Province ____________________ Country ____________________ Postal Code __ __ __-__ __ __

Home Phone (_______) ____________________ Work Phone (_______) ____________________ Cell Phone (______) ____________________

E-Mail Address ____

Canadian Citizen (*check one*): ☐ Yes ☐ No, citizen of ______________________________

If Minister, check one: ☐ Ordained ☐ Commissioned ***IMPORTANT: Please provide a copy of your current credentials with this Form.***

Date of ordination or first date of commission is ________/________/________

II. EMPLOYMENT INFORMATION

Employer ____ Date of Employment _______/_______/_______

Mailing Address ____

City ____________________ Province ____________________ Country ____________________ Postal Code __ __ __-__ __ __

Contact Name ____

Phone (_______) ____________________ E-mail Address ______________________________

Applicant's Position ____ Date Dues Will Begin ______/_______/_______
(Minister, Associate Minister, Educator, Administrative Assistant, Health Care Professional, etc.)

III. FAMILY INFORMATION

Check Marital Status: ☐ Single ☐ Divorced ☐ Widow(er)

☐ Married/common law relationship; if checked, date of marriage or common law relationship _____/_____/______

IMPORTANT: If you are married or in a common law relationship, please return a copy of your marriage certificate or statutory declaration of common law union with this Form. Your spouse is your automatic beneficiary under the RCA.

Spouse Name ____ Social Insurance Number __ __ __-__ __ __- __ __ __
(first, middle, last/family name)

Spouse Date of Birth _______/_______/_______ Canadian Citizen (*check one*): ☐ Yes ☐ No, citizen of ____________________ _____

Full Name, Date of Birth, Sex, and Social Insurance Number of Member's **Natural Born Children** or **Legally Adopted Children**:

	Name (first, middle, last/family name)	Birthdate	Gender	Social Insurance Number
1		/ /		- -
2		/ /		- -
3		/ /		- -
4		/ /		- -
5		/ /		- -

If you do not have a spouse or any minor children, provide the name(s) of parent(s) who are dependent on you:

First Dependent Parent Name ____
(first, middle, last/family name)

Home Address ____

City ____________________ Province ____________________ Country ____________________ Postal Code __ __ __-__ __ __

Social Insurance Number __ __ __-__ __ __- __ __ __ Date of Birth _______/_______/_______

Second Dependent Parent Name ____

(first, middle, last/family name)

Home Address ____

City ______________________________ Province ______________________ Country ____________________ Postal Code __ __ __-__ __ __

Social Insurance Number __ __ __-__ __ __- __ __ __ Date of Birth _______/_______/_______

IV. DUES INFORMATION

Current monthly compensation (for purposes of determining initial dues):

a.	Total cash salary per month paid to applicant by employer	$ ________________	To determine monthly salary, divide annual salary by 12. If paid weekly, multiply by 52, then divide by 12.
b.	Housing allowance or fair rental value of housing	$ ________________	If housing allowance is provided, add exact amount for month. If actual housing is provided, add the greater of monthly fair rental value or 25% of monthly cash salary.
	Total monthly Compensation Base on which dues will be paid	**$** ________________	**NOTE**: *This amount will change as your salary or allowances change over time. You and your employer are responsible for calculating the required amount of dues.*

Please indicate below how RCA dues will be paid:

☐ Employer pays full 14% dues as an employer contribution.

☐ *Employer pays 11% dues as an employer contribution, and member pays 3% dues as an employee contribution.

☐ *Employer pays ___________% dues as an employer contribution, and member pays ___________% dues as an employee contribution (*must total 14%).*

If you are not a minister, partial dues equal to at least 6% of your Compensation Base may be paid to the Pension Plan. **Partial dues will result in a reduced pension.**

☐ Employer pays 6% dues as an employer contribution.

☐ *Employer pays ___________ % dues as an employer contribution, and member pays ____________% dues as an employee contribution (*must total 6%*).

***IMPORTANT: If you are required by the terms of your employment to make employee contributions to the RCA, the contributions will be tax deductible if the total amount of employee contributions is less than the total amount of employer contributions made on your behalf. Voluntary employee contributions are not tax deductible.**

V. DESIGNATION OF BENEFICIARIES

Generally, the terms of the RCA govern how death benefits will be paid. However, in the event that you die without a surviving spouse with regard to the Pensioner Death Benefit, or without a surviving spouse or surviving children with regard to the Salary Continuation Benefit, these benefits will be paid to the beneficiary(ies) you designate on this Enrollment Form.

Designate the person, trust or entity you choose to receive any benefits payable from the RCA in the event of your death. If you designate a trust as a beneficiary, include the trust's name and address, the date the trust was created, and the trustee's name. You are not limited to three primary and three contingent beneficiaries. To designate additional beneficiaries, please attach and sign a separate piece of paper.

Unless otherwise indicated, death benefits will be paid in equal shares to your primary beneficiaries who are living at the time of your death. If no primary beneficiary is living at your death, unless otherwise indicated, death benefits will be paid in equal shares to your contingent beneficiaries who are living at the time of your death. If you name multiple primary or contingent beneficiaries, and one of them predeceases you, the percentage of that beneficiary's designated share shall be divided equally among the surviving primary or contingent beneficiaries, as applicable.

Failure to include a social insurance number for each designated beneficiary, if applicable, may delay distributions at your death.

Primary Beneficiaries ***The total percentage to all primary beneficiaries must equal 100%.***	**Percentage of Benefit**
Individual or Trust Name ____________________ (first, middle, last/family name) Mailing Address ____________________ (street, city, province, postal code) Primary Phone (________)______________ Relationship to Applicant/Trustee Name ____________________ Social Insurance Number __ __ __-__ __ __- __ __ __ Birth or Trust Date ________/________/________	_________%
Individual or Trust Name ____________________ (first, middle, last/family name) Mailing Address ____________________ (street, city, province, postal code) Primary Phone (________)______________ Relationship to Applicant/Trustee Name ____________________ Social Insurance Number __ __ __-__ __ __- __ __ __ Birth or Trust Date ________/________/________	_________%
Individual or Trust Name ____________________ (first, middle, last/family name) Mailing Address ____________________ (street, city, province, postal code) Primary Phone (________)______________ Relationship to Applicant/Trustee Name ____________________ Social Insurance Number __ __ __-__ __ __- __ __ __ Birth or Trust Date ________/________/________	_________%

Contingent Beneficiaries If all of your primary beneficiary(ies) die before you, any benefits payable in the event of your death will be paid to your contingent beneficiary(ies). ***The total percentage to all contingent beneficiaries must equal 100%.***	**Percentage of Benefit**
Individual or Trust Name ____________________ (first, middle, last/family name) Mailing Address ____________________ (street, city, province, postal code) Primary Phone (________)______________ Relationship to Applicant/Trustee Name ____________________ Social Insurance Number __ __ __-__ __ __- __ __ __ Birth or Trust Date ________/________/________	_________%
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Individual or Trust Name ____________________ (first, middle, last/family name) Mailing Address ____________________ (street, city, province, postal code) Primary Phone (________)______________ Relationship to Applicant/Trustee Name ____________________ Social Insurance Number __ __ __-__ __ __- __ __ __ Birth or Trust Date ________/________/________	_________%

VI. APPLICANT CERTIFICATION AND SIGNATURE

In signing this Enrollment Form, I agree to be bound by all terms of the RCA, as it may be amended from time to time. I understand that I will be mailed a copy of the RCA Member Resource Book upon the Pension Fund's receipt of this Enrollment Form, and that I can also access the Member Resource Book and other information regarding the RCA electronically at www.pensionfund.org.

I certify that the information provided on this Enrollment Form is accurate. I have attached a certified copy of my birth certificate and, if I am married or have a common law spouse for purposes of the RCA, I have attached a copy of my marriage certificate or statutory declaration of common law union, as applicable, to this Form. **I agree that I will timely notify the Pension Fund of any changes to the information provided on this Form, including changes in my Compensation Base, how Dues will be paid, to my marital status, and to the status of my dependent children and my dependent parents.** I understand that failure to provide accurate and timely information may result in a reduction of my benefits.

I designate the person(s) or entity(ies) named in Section V of this Enrollment Form as beneficiaries for any of my benefits under the RCA that are not otherwise payable according to the terms of the RCA. I reserve the right to revoke this designation at any time by submitting a new Beneficiary Designation Form. I understand that my beneficiary designation on this Enrollment Form will remain in effect until I complete, sign, and submit an updated Beneficiary Designation Form to the Pension Fund at a later date.

I understand that if I have a severance from employment with my Employer and I am not yet vested in my benefits under the RCA, the RCA will return my member dues to me in a single lump sum distribution. I further understand that if I do not timely direct the RCA as to how to pay my member dues on the applicable form, the Pension Fund has the right to automatically distribute my member dues to me in a direct cash payment to the address set forth in Section I.

Applicant Signature ____ **Date** ________/________/________

VII. EMPLOYER CERTIFICATION AND SIGNATURE

I certify that I am authorized to sign this Enrollment Form on behalf of the Employer of the applicant. I certify either that a Participation Agreement has already been submitted on behalf of the Employer or is being submitted contemporaneously with this Enrollment Form, and that the applicant is eligible to participate in the RCA under the terms of the RCA and the Participation Agreement.

I certify that the information set forth in Section IV of this Form is accurate and that payment for the initial dues on behalf of the applicant, as set forth in Section IV, is enclosed with this Form. I agree that I will timely notify the Pension Fund of any changes to the information set forth in Section IV, including the applicant's Compensation Base and how dues will be paid. I further agree to notify the Pension Fund immediately if the applicant severs employment with the Employer.

Employee Participation Start Date ________/________/________

Employer Representative Signature ____ **Date** ________/________/________

Print Name ____

SEND FORM WITH INITIAL DUES PAYMENT TO:

Pension Fund of the Christian Church
P O Box 6251 - Indianapolis, Indiana 46206-6251
Toll Free: 1.866.495.7322 • Phone: 317.634.4504 • Fax: 317.634.4071
E-mail: pfcc1@pensionfund.org • Website: www.pensionfund.org

Membership Number _________________________ **Enrollment Date** ________/________/________

Initial Dues Remitted $________________________

[Do not write in this box – for Pension Fund use only]