Pension Fund of the Christian Church

PENSION PLAN ENROLLMENT FORM

PLEASE TYPE OR PRINT CLEARLY -

I. APPLICANT INFORMATION

Full Legal Name _____
(first) (middle) (last/family name)

Title Preference (*check one*): ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Rev. ☐ Dr. ☐ Chap. ☐ None

Social Security No./ITIN __ __ __-__ __-__ __ __ __ Date of Birth _____/_____/_____ Gender: ☐ M ☐ F

Home Address _____

City _____ State _____ Country _____ Zip Code _____-_____

Home Phone Number (_____) _____ Work Phone Number (_____) _____ Cell Phone Number (_____) _____

E-Mail Address _____

US Citizen (*check one*): ☐ Yes ☐ No, citizen of _____ ***If you are not a US citizen, you must have an ITIN to enroll.***

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

Date of ordination or first date of commission/license _____/_____/_____

II. EMPLOYMENT INFORMATION

Employer _____ Date of Employment _____/_____/_____
(enter "self-employed minister," if applicable)

Mailing Address _____

City _____ State _____ Country _____ Zip Code_____-_____

Contact Name _____

Phone Number (_____) _____ E-Mail Address _____

Applicant's Position _____
(Minister, Associate Minister, Educator, Administrative Assistant, Health Care Professional, Seminary Student, etc.)

III. FAMILY INFORMATION

Check Marital Status: ☐ Single ☐ Divorced ☐ Widow(er) ☐ Married; if checked, date of marriage _____/_____/_____

IMPORTANT: If you are married, please return a copy of your marriage certificate/proof of marriage with this Form. Your spouse is your automatic beneficiary under the Pension Plan.

Spouse Name _____ Social Security No./ITIN __ __ __-__ __-__ __ __ __
(first) (middle) (last/family name)

Spouse's Date of Birth _____/_____/_____ US Citizen (*check one*): ☐ Yes ☐ No, citizen of _____

Spouse's Gender: ☐ M ☐ F

Full Name, Date of Birth, Sex, and Social Security Number/ITIN of applicant's **Natural Born Children** or **Legally Adopted Children** who are under age 21 only:

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

If applicant does not have a spouse or any minor children, provide the name(s) of living parent(s):

First Living Parent Name _____
(first) (middle) (last/family name)

Home Address _____

City _____ State _____ Country _____ Zip Code _____-_____

Social Security No./ITIN __ __ __-__ __-__ __ __ __ Date of Birth _____/_____/_____

Second Living Parent Name _____
(first) (middle) (last/family name)

Home Address _____

City _____ State _____ Country _____ Zip Code _____-_____

Social Security No./ITIN __ __ __-__ __-__ __ __ __ 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. Seminary students participating in the Student Gift Membership Program should enter $500.
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.
c.	Social Security offset for ministers	$ _____	If a Social Security offset is provided to ministers, include this amount.
d.	Employer contributions to TDRA	$ _____	If employer contributions are made to the TDRA on your behalf, add exact amount for one month. If paid in a single lump sum each year, divide by 12.
	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 and notifying Pension Fund of any changes.*

Full dues under the Pension Plan must equal 14% of your Compensation Base. If you are a minister, full dues must be paid to the Pension Plan. Please elect how the dues will be paid:

☐ Employer pays full dues equal to 14% of Compensation Base as an employer contribution.

☐ ***Must total 14%.*** Employer pays dues equal to _____% of Compensation Base as an employer contribution, and member pays dues equal to _____% of Compensation Base as ☐ a *pre-tax* employee contribution **or** ☐ an *after-tax* employee contribution.

Partial dues under the Pension Plan must equal at least 6% of your Compensation Base. If you are not a minister, partial dues may be paid to the Pension Plan. ***Partial dues will result in a reduced pension. For example, partial dues of 6% will result in a pension that is approximately 25% of the pension you would receive if full dues had been paid.*** Please elect how the dues will be paid:

☐ Employer pays dues equal to 6% of Compensation Base as an employer contribution.

☐ ***Must total at least 6%.*** Employer pays dues equal to _____% of Compensation Base as an employer contribution, and member pays dues equal to _____% of Compensation Base as ☐ a *pre-tax* employee contribution **or** ☐ an *after-tax* employee contribution.

THE ABOVE ELECTIONS MUST BE PERMITTED UNDER THE EMPLOYER'S PARTICIPATION AGREEMENT. IF THE PARTICIPATION AGREEMENT ALLOWS MEMBERS TO EACH ELECT A DIFFERENT PERCENTAGE OF EMPLOYEE DUES ON A PRE-TAX BASIS, THE MEMBER MUST ALSO COMPLETE A SALARY CONTRIBUTION AGREEMENT.

V. DESIGNATION OF BENEFICIARIES

Generally, the terms of the Pension Plan govern how death benefits will be paid. However, in the event that you die without a surviving spouse in regards to the Pensioner Death Benefit, or without a surviving spouse or surviving children in regards to the Salary Continuation Benefit, these benefits will be paid to the beneficiary(ies) you designate on this Enrollment Form. ***If you are currently married or have minor children, you are not required to complete this section.***

Designate the person, trust, or entity you choose to receive any benefits payable from the Pension Plan 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 stating the additional names and identifying information.

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 amongst the surviving primary or contingent beneficiaries, as applicable.

Failure to include a social security number and current contact information for each designated beneficiary, if applicable, may delay distributions at your death.

Primary Beneficiaries [*not applicable if you are married*] ***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, state, zip code) Primary Phone (________)______________ Relationship to Applicant/Trustee Name ________________ Social Security No./ITIN __ __ __-__ __-__ __ __ __ Birth or Trust Date ________/________/________	_________%
Individual or Trust Name ____________________ (first, middle, last/family name) Mailing Address ____________________ (street, city, state, zip code) Primary Phone (________)______________ Relationship to Applicant/Trustee Name ________________ Social Security No./ITIN __ __ __-__ __-__ __ __ __ Birth or Trust Date ________/________/________	_________%
Individual or Trust Name ____________________ (first, middle, last/family name) Mailing Address ____________________ (street, city, state, zip code) Primary Phone (________)______________ Relationship to Applicant/Trustee Name ________________ Social Security No./ITIN __ __ __-__ __-__ __ __ __ Birth or Trust Date ________/________/________	_________%

Contingent Beneficiaries [*not applicable if you are married*] 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, state, zip code) Primary Phone (________)______________ Relationship to Applicant/Trustee Name ________________ Social Security No./ITIN __ __ __-__ __-__ __ __ __ Birth or Trust Date ________/________/________	_________%
Individual or Trust Name ____________________ (first, middle, last/family name) Mailing Address ____________________ (street, city, state, zip code) Primary Phone (________)______________ Relationship to Applicant/Trustee Name ________________ Social Security No./ITIN __ __ __-__ __-__ __ __ __ Birth or Trust Date ________/________/________	_________%
Individual or Trust Name ____________________ (first, middle, last/family name) Mailing Address ____________________ (street, city, state, zip code) Primary Phone (________)______________ Relationship to Applicant/Trustee Name ________________ Social Security No./ITIN __ __ __-__ __-__ __ __ __ Birth or Trust Date ________/________/________	_________%

VI. APPLICANT CERTIFICATION AND SIGNATURE

By signing this Enrollment Form, I make the following certifications:

- I agree to be bound by all terms of the Pension Plan, as it may be amended from time to time, and all administrative policies and procedures adopted by Pension Fund with respect to the Pension Plan.
- I understand that I can access the Pension Plan Member Resource Book and other information regarding the Pension Plan electronically at www.pensionfund.org, and that I can also request Pension Fund to mail me a copy of the Pension Plan Member Resource Book.

- I certify that the information provided on this Enrollment Form is accurate. I have attached a copy of my birth certificate and, if I am married, I have attached a copy of my marriage certificate/proof of marriage.
- I agree that I will timely notify Pension Fund of any changes to the information provided on this Form, **including changes in my Compensation Base, in how Dues will be paid, to my marital status, and to the status of my dependent children and my parents.** I understand that failure to provide accurate and timely information may result in a reduction of my benefits.
- I understand that if my Employer's Participation Agreement permits members to each elect a different percentage of employee dues on a pre-tax basis, I must complete and submit a separate Salary Contribution Agreement to my Employer which directs my Employer to reduce my salary by a stated percentage each pay period and to contribute such percentage to the Pension Plan.
- I designate the person(s) or entity(ies) named in Section V of this Enrollment Form as beneficiaries for all benefits under the Pension Plan that are not otherwise payable according to the terms of the Pension Plan. 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 Pension Fund at a later date.
- I acknowledge and agree that pension benefits from the Pension Plan will be directly deposited by ACH to my bank account on record with Pension Fund or to another bank account that I designate on my application for benefits.

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 Pension Plan under the terms of the Pension Plan and the Participation Agreement.

I certify that the information provided in Section IV of this Form is accurate and that payment for the initial dues on behalf of the applicant, as provided in Section IV, is enclosed with this Form. I agree that I will timely notify Pension Fund of any changes to the information provided in Section IV, including the applicant's Compensation Base and how dues will be paid. If the applicant has entered into a Salary Contribution Agreement with the Employer, I am submitting a copy of this Agreement contemporaneously with this Enrollment Form. I further agree to submit any revisions to the Salary Contribution Agreement to Pension Fund on or before such revisions become effective.

I further agree to notify Pension Fund immediately if the applicant terminates employment with the Employer.

Employee Participation Start Date _____/_____/_____

Employer Representative Signature _____ **Date** _____/_____/_____

Printed Name _____

SEND FORM WITH INITIAL DUES AND RELATED FORMS, IF APPLICABLE, TO:

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

Member Ref. No._____ **Enrollment Date** _____/_____/_____ **Initial Dues Remitted $**_____

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