Pension Fund of the Christian Church

APPLICATION FOR THE STUDENT GIFT MEMBERSHIP PROGRAM

Students preparing for ministry may become a member in the Pension Plan of the Pension Fund of the Christian Church (Disciples of Christ) ("Pension Plan") by participating in the Student Gift Membership Program ("Program"). The Program will pay dues equal to $70 per month to the Pension Plan on behalf of the student, which is in addition to any dues paid by an employer for services provided by the student. To be eligible to participate in the Program, a student must satisfy (1) **or** (2):

(1) The individual must be:

- a current student at an accredited theological education institution seeking a ministry degree;
- enrolled at the institution at least six credit/semester hours for the semester/term (special consideration will be given for certain degree requirements that require intensive/focused ministry related instruction, such as CPE or ministry internships); and
- a Disciples of Christ student "under care" of a recognized region/ministry of the Church.

(2) The individual must be a student in the Stone-Campbell Restoration Movement tradition in supervised ministry (*e.g.*, "under care" or in an approved ministry internship).

The student must also complete and return a Pension Plan Enrollment Form.

Participation in the Program is approved for up to a 12 month period, and can be renewed for up to three separate 12 month periods, for a total of 48 months of participation.

Applications for the Program are accepted year round, and approval is for the 12 month period beginning with the month following approval of your completed Application and enrollment in the Pension Plan. A new Application must be submitted each 12 month period to continue participation in the Program.

Please complete Sections I, II and III. If you are an eligible individual under (1) above, forward this Application for certification and signature under Sections IV and V to an authorized representative of the Region/Ministry with respect to which you are under care and to the school which you attend. If you are an eligible individual under (2) above, forward this Application for certification and signature under Section VI to an authorized representative of a recognized ministry in the Stone-Campbell Restoration Movement tradition with respect to which you are under care or in an approved ministry internship.

- PLEASE TYPE OR PRINT CLEARLY -

I. STUDENT INFORMATION

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

Home Address _____

City _____ State _____ Country _____ Zip Code _____-_____

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

E-Mail Address _____

I am affiliated with the following branch of the Stone-Campbell Restoration Movement:

☐ Christian Church (Disciples of Christ) ☐ Christian Churches/Churches of Christ ☐ Churches of Christ in the U.S. (Acapella)

II. SCHOOL INFORMATION [IF APPLICABLE]

Name of School _____

Address _____

City _____ State _____ Country _____ Zip Code _____-_____

Name of Registrar _____ Daytime Phone Number (_____)_____

Number of Credit/Semester Hours Completed _____ Number of Credit/Semester Hours Required for Degree _____

Expected Graduation Date _____ 20_____ Degree You Are Seeking _____

III. STUDENT CERTIFICATION AND SIGNATURE

By signing this Application, I make the following certifications:

- I certify that I am eligible to participate in the Student Gift Membership Program, that I understand and agree to the terms of the Program, including the applicable vesting schedule, and that I am committed to fulfilling all of the requirements for Program participation.
- I understand that the terms of my participation in the Pension Plan are governed by the Pension Plan, and that if there is any conflict between the Program and the Pension Plan, the Pension Plan will control.
- I acknowledge that I am required to immediately notify Pension Fund if I do not satisfy the Program's minimum enrollment requirements at any time during the 12 month period that this Application covers.
- I understand that I must submit a new Application each academic year to continue participation in the Program.
- I understand that, unless already on file with Pension Fund, I am required to provide with this Application a completed Pension Plan Enrollment Form.

Student Signature _____ **Date** _____/_____/_____

IV. REGION/MINISTRY CERTIFICATION AND SIGNATURE

I certify that the individual identified in Section I is a student who is currently "under care" of the following region/ministry _____.

Region/Ministry Representative Signature _____ **Date** _____/_____/_____

Printed Name _____ **Phone Number** (_____)_____

Title _____

V. SCHOOL CERTIFICATION AND SIGNATURE

I certify that the individual identified in Section I is a student at the school identified in Section I, and that such student is currently enrolled at least six credit/semester hours per semester/term (or the student is taking an intensive program such as an internship or CPE for which additional course work is not recommended, or is on a ministry internship).

School Representative Signature _____ **Date** _____/_____/_____

Printed Name_____ **Phone Number** (_____)_____

Title _____

VI. STONE-CAMPBELL MINISTRY CERTIFICATION AND SIGNATURE

I certify that the individual identified in Section I is a student "under care" or in an approved ministry internship of the following ministry in the Stone-Campbell Restoration Movement tradition _____.

Ministry Representative Signature _____ **Date** _____/_____/_____

Printed Name_____ **Phone Number** (_____)_____

Title _____

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

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

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

Home Address _____

City _____ State _____ Country _____ Zip _____-_____

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

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 ***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 Student Gift Member Date of Employment _____/_____/_____
(enter "self-employed" minister, if applicable)

Mailing Address _____

City _____ State _____ Country _____ Zip _____-_____

Contact Name _____

Phone (_____) _____ E-mail Address _____

Applicant's Position _____ Date Dues Will Begin _____/_____/_____
(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 _____

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

	Name (first, middle, last/family name)	Birthdate	Gender	Social Security Number/ITIN
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 _____ State _____ Country _____ Zip _____-_____

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

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

Home Address _____

City _____ State _____ Country _____ Zip _____-_____

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	$ 500.00	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 month. If paid in a single lump sum each year, divide by 12.
	Total monthly Compensation Base on which dues will be paid	$ 500.00	**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 Pension Plan 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 <u>not</u> 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:** Employee contributions, if any, will be paid as ☐ a ***pre-tax employee contribution <u>or</u> as ☐ an ***after-tax*** employee contribution.

V. DESIGNATION OF BENEFICIARIES (*not required if you are married or have minor children*)

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 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. ***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.

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 security 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, state, zip) 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) 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) Primary Phone (________)______________ Relationship to Applicant/Trustee Name ________________ Social Security No./ITIN __ __ __-__ __-__ __ __ __ 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, state, zip) 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) 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) Primary Phone (________)______________ Relationship to Applicant/Trustee Name ________________ Social Security No./ITIN __ __ __-__ __-__ __ __ __ Birth or Trust Date _______/_______/_______	_________%

VI. APPLICANT CERTIFICATION AND SIGNATURE

In signing this Enrollment Form, 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 the Pension Fund with respect to the Pension Plan. I understand that I will be mailed a copy of the Pension Plan 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 Pension Plan 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, I have attached a copy of my marriage certificate/proof of marriage. **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 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 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 Pension Plan, the Pension Plan will return my member dues to me in a single lump sum distribution. I further understand that if I do not timely direct the Pension Plan 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 Pension Plan under the terms of the Pension Plan 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]