

How to Enroll

1. Complete the enrollment form. Check the box marked: Plan A for member coverage only. Check the box marked Plan B for member coverage and coverage for your spouse.
2. Name as your beneficiary your spouse or any other person. Please use their own names and relationship (e.g., Mary E. Smith, wife).
3. If beneficiaries are simply listed, the benefits will be divided equally. If you wish other division of benefits, see the other side of enrollment form for standard wording.
4. Please do not name yourself as a beneficiary since the member is automatically the only beneficiary for the spouse's coverage.
5. Make check payable to Pension Fund of the Christian Church.
6. Return the completed enrollment form, with your check, in the envelope provided and mail to Pension Fund of the Christian Church, P.O. Box 6251 Indianapolis, IN 46206-6251.

NOTE: To change a beneficiary, please request a Change of Beneficiary form from Pension Fund.

Amount of Insurance

When you become eligible, you may purchase this coverage in Principal Sums of \$20,000, \$50,000, \$100,000, \$150,000, \$200,000, or \$300,000. (Refer to Principal Sum Schedule on following page.) You may request a change in the amount of insurance by signing a new enrollment card at any time prior to any July 1 anniversary date. On the July 1st coinciding with, or next following, retirement or attainment of age 70, your Principal Sum will reduce to \$50,000 or remain at \$20,000 if you were insured for that amount. (ALL changes will occur on a July 1 anniversary date.) If you cover your spouse, your spouse will be covered for 50% of your Principal Sum for Accidental Death and Dismemberment. The spouse is not covered for total and permanent disability.



Churchwide Accident Insurance Enrollment

COMPANY USE ONLY

Accounting No. PFCC

Effective Date ____/____/____

Person Insured (Print)

GROUP POLICY HOLDER

Group Policy No.

Pension Fund of the Christian Church

VAR 50114

Last Name* First Name* Middle Initial*

☐ FEMALE ☐ MALE / / - -

Sex* Birthdate* Social Security #* Home Address*

(Check one:) ☐ PENSION PLAN MEMBER

☐ ELIGIBLE FOR PENSION PLAN

Name of Employer

I hereby designate the following as my beneficiary(ies) under the above policy number(s):

PRIMARY BENEFICIARY(IES):

INSURE ME FOR A PRINCIPAL SUM OF*:

(Check one:)

- ☐ Plan 1** - \$ 20,000
- ☐ Plan 2** - \$ 50,000
- ☐ Plan 3 - \$100,000
- ☐ Plan 4 - \$150,000
- ☐ Plan 5 - \$200,000
- ☐ Plan 6 - \$300,000

(Check one:)

- ☐ Plan A Member only
- ☐ Plan B Member and 1/2 on Spouse

Name of Beneficiary (Print name as Mary Doe, NOT Mrs. John Doe.)

Relationship

/ / - -

Percentage Birthdate Social Security # Home Address

Signature of Applicant*

Date Signed

* Required

** Retirees or persons age 70, but under age 80, may apply for Plan 1 and Plan 2 only.

MAKE CHECK PAYABLE TO:
"Pension Fund of the Christian Church"