

# CONTINUING COVERAGE

FOR INTERIM PASTORS CALLED BY A SYNOD COUNCIL

## **A** YOUR PERSONAL INFORMATION

NAME (FIRST, MIDDLE INITIAL, LAST)

SOCIAL SECURITY NUMBER

ADDRESS

E-MAIL ADDRESS

ELCA SYNOD AFFILIATION

CITY

STATE

ZIP CODE

COUNTY

( )

( )

( )

( )

HOME PHONE

WORK PHONE

CELL PHONE

FAX

NAME OF SPOUSE (FIRST, MIDDLE INITIAL, LAST)

Is your spouse separately enrolled in the ELCA Pension and Other Benefits Program?  Yes  No

If yes, name of spouse's sponsoring employer \_\_\_\_\_

## **B** ELCA EXTENDED BENEFITS

**1.** I elect to continue the following benefits at my own expense:

- health benefits coverage and survivor benefits coverage
- disability benefits coverage

**2.** To be eligible for coverage, I verify that I am either:

- serving under call from a synod council and between assignments
- going on leave from call after completing an interim call from a synod council

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**C ELCA HEALTH BENEFITS PLAN COVERAGE ELECTION**

**1. Elect one of the following options for coverage under the ELCA Health Benefits Plan** (check [✓] one)

- Member only
- Member and spouse
- Member and child(ren)
- Member, spouse and child(ren)
- Waive** health coverage

**To waive coverage, you must be covered under employer-provided group coverage other than the coverage provided by a sponsoring employer. A waiver cannot be retroactive.** (Go to Section C4.)

**2. ELCA health coverage**

List yourself and all eligible dependents who will be covered under the ELCA Health Benefits Plan. Attach a separate sheet of paper if more space is needed.

	SELF	Provided in Section A			Is individual enrolled in Medicare Part A/B?	
NAME					<input type="checkbox"/> Yes <input type="checkbox"/> No	
NAME	SPOUSE, CHILD	- -	SOCIAL SECURITY NUMBER	GENDER (F OR M)	BIRTH DATE (MM/DD/YYYY)	<input type="checkbox"/> Yes <input type="checkbox"/> No
NAME	CHILD	- -	SOCIAL SECURITY NUMBER	GENDER	BIRTH DATE	<input type="checkbox"/> Yes <input type="checkbox"/> No
NAME	CHILD	- -	SOCIAL SECURITY NUMBER	GENDER	BIRTH DATE	<input type="checkbox"/> Yes <input type="checkbox"/> No

**3. ELCA health coverage for eligible dependent child, age 19 or older** (Attach a separate sheet for additional children.)

If your child is age 19 or older and eligible for coverage, please complete the following:

CHILD'S NAME	NAME OF EDUCATIONAL INSTITUTION
CURRENT OR NEXT SCHOOL TERM BEGINS (MM/DD/YYYY)	ENDS (MM/DD/YYYY)
	ANTICIPATED GRADUATION DATE (MM/DD/YYYY)

**4. Waive ELCA health coverage** (Other employer-provided group coverage must be verified.)

List yourself and all eligible dependents for whom coverage is waived. (Also complete Sections D and E.)

	SELF	Provided in Section A	
NAME			PLAN NAME AND EMPLOYER PROVIDING OTHER COVERAGE
NAME	SPOUSE, CHILD	- -	SOCIAL SECURITY NUMBER
			GENDER (F OR M)
			BIRTH DATE (MM/DD/YYYY)
NAME	CHILD	- -	PLAN NAME AND EMPLOYER
			SOCIAL SECURITY NUMBER
			GENDER
			BIRTH DATE
NAME	CHILD	- -	PLAN NAME AND EMPLOYER
			SOCIAL SECURITY NUMBER
			GENDER
			BIRTH DATE

**Enclose a copy of the other employer-provided group coverage identification card or a letter from the employer to confirm coverage.**

**D** SIGNATURE OF MEMBER

I understand I must enroll in the benefits indicated in Section B within 60 days of ending an assignment where my employer sponsored me in the ELCA Pension and Other Benefits Program. I understand coverage starts the day after this assignment ended.

I agree to continue coverage in the Pension and Other Benefits Program as indicated in Section B, at my own expense.

\_\_\_\_\_  
SIGNATURE OF MEMBER **(REQUIRED)**

\_\_\_\_\_  
DATE (MM/DD/YYYY)

**E** SIGNATURE OF BISHOP

I certify this pastor is serving under call or has completed an interim call for this synod.

\_\_\_\_\_  
NAME OF CALLING ELCA SYNOD

\_\_\_\_\_  
SIGNATURE OF BISHOP **(REQUIRED)**

\_\_\_\_\_  
DATE (MM/DD/YYYY)

**Return this completed form and any requested documentation to the Board of Pensions Service Center.**

Service Center  
ELCA Board of Pensions  
800 Marquette Ave., Suite 1050  
Minneapolis, MN 55402-2892

(800) 352-2876 • (612) 333-7651  
Fax: (612) 334-5399  
*mail@elcabop.org • www.elcabop.org*