EPC
Benefit Resources, Inc.

Welcome to the EPC Family!

We are excited to share the benefits available to you and your staff. EPC Benefit Resources, Inc. (BRI) is a solely owned subsidiary of the EPC offering medical, dental, vision, term life, AD&D, long-term disability, and voluntary insurance benefits, including accident and short-term disability. We strive to provide you with great customer service, support, and information to help you make the best possible decisions for you and your church staff. The enrollment process can be a bit complex, and we want to make it as smooth as possible.

To enroll in our benefits program, a Church Benefit Election Form, a Church Billing Setup Form, and the EPC Benefits Online Portal Access Request Form is required to set up your church with benefits.

- **The Church Benefit Election Form** articulates the benefits your church will offer to your staff.
- **The Church Billing Setup Form** tells us who your administrative contact for your church is, and where invoices should be sent.
- **The EPC Benefits Online Portal Access Request Form** gives you access to the EPC Benefits Online Portal used by administrators who manage the enrollment, eligibility, and invoicing for Medical, Prescription Drug, Dental, Vision, Life, Accidental Death & Dismemberment (AD&D), and Long-Term Disability (LTD) Plans.

You also will need the **Medical Plan Enrollment/Change Form** to enroll your employees for the first time in our health plans. For employees that enroll in our LIFE/LTD, use the enclosed **The Hartford Life/AD&D Beneficiary Designation Form.**

Note that new churches will not have a customer number yet; this will be assigned after we receive your information. Submit completed forms by mail, fax, or email to:

EPC Administration Office
60 Boulevard of the Allies, 5th Floor
Pittsburgh, PA 15222
Fax 412-224-4465
epc@cdsadmin.com

After the forms are processed, the church will receive email confirmation that your church has been enrolled and a customer number (keep for future reference).

We have created the Church Administrator Resources webpage and Benefit Administrator's Handbook as a resource of information. We hope they are useful for you.

We are here to help or answer your questions. Please let us know how we can assist you.

The BRI Team

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BENEFIT PLANS ELECTION FORM

Please provide information on the 2024 Benefit Plan Elections you offer to your employees. BRI uses this for tracking purposes. This form does not limit you as the employer from providing additional benefits to your employees in the future. For information on our benefits, see www.epc.org/benefits.

Church Name	**Billing ID**
City/State/ZIP	**Phone**
Administrator Name	**Email**

2024 EPC Benefit Plan Choices offered to *EPC ORDAINED STAFF*

	Does your church offer this plan? (Y) or (N)	*Plan types*	*Church Pays %*	*Employee Pays %*	*Comments*
MEDICAL Any combination of Medical Plans may be offered		**Platinum POS**			
		Gold POS			
		Gold HDHP			
		Silver POS			
		Bronze HDHP			
DENTAL		**Delta Dental** (*High Plan*)			
		Delta Dental *(Low Plan)*			
VISION		**National Vision Administrators**			
LIFE/AD&D/LONG-TERM DISABILITY (LTD)		**The Hartford Life/AD&D/LTD**			
403(b)(9) Retirement Plan (Required for Ordained)		Adoption Agreement (available at *www.epc.org/benefits/2024churchadministratorresources*) needs to be completed and on file with the BRI office. Email completed form to *benefits@epc.org*			
Voluntary Insurance through Colonial Life		**Employee/Dependent Life**			
		Short-Term Disability			
		Accident Coverage			
		Critical Illness Coverage			
Amplifon Hearing Aid Discount Program		This program provides participants with discounted hearing aids and services throughout the country.			

2024 EPC Benefit Plan Choices offered to *EPC OTHER STAFF I*					
Benefit Class: _____ (Specify: non-EPC ordained, salaried, hourly, management, etc.)					
	Does your church offer this plan? (Y) or (N)	***Plan types***	***Church Pays %***	***Employee Pays %***	***Comments***
MEDICAL Any combination of Medical Plans may be offered		**Platinum POS**			
		Gold POS			
		Gold HDHP			
		Silver POS			
		Bronze HDHP			
DENTAL		**Delta Dental** (*High Plan)*			
		Delta Dental *(Low Plan)*			
VISION		**National Vision Administrators**			
LIFE/AD&D/LONG-TERM DISABILITY (LTD)		**The Hartford Life/AD&D/LTD**			
403(b)(9) Retirement Plan (Required for Ordained)		Adoption Agreement (available at *www.epc.org/benefits/2024churchadministratorresources*) needs to be completed and on file with the BRI office. Email completed form to *benefits@epc.org*			
Voluntary Insurance through Colonial Life		**Employee/Dependent Life**			
		Short-Term Disability			
		Accident Coverage			
		Critical Illness Coverage			
Amplifon Hearing Aid Discount Program		This program provides participants with discounted hearing aids and services throughout the country.			

2024 EPC Benefit Plan Choices offered to *EPC OTHER STAFF II*

Benefit Class: _____ (Specify: non-EPC ordained, salaried, hourly, management, etc.)

	Does your church offer this plan? (Y) or (N)	*Plan types*	*Church Pays %*	*Employee Pays %*	*Comments*
MEDICAL Any combination of Medical Plans may be offered		**Platinum POS**			
		Gold POS			
		Gold HDHP			
		Silver POS			
		Bronze HDHP			
DENTAL		**Delta Dental** (*High Plan)*			
		Delta Dental *(Low Plan)*			
VISION		**National Vision Administrators**			
LIFE/AD&D/LONG-TERM DISABILITY (LTD)		**The Hartford Life/AD&D/LTD**			
403(b)(9) Retirement Plan (Required for Ordained)		Adoption Agreement (available at *www.epc.org/benefits/2024churchadministratorresources*) needs to be completed and on file with the BRI office. Email completed form to *benefits@epc.org*			
Voluntary Insurance through Colonial Life		**Employee/Dependent Life**			
		Short-Term Disability			
		Accident Coverage			
		Critical Illness Coverage			
Amplifon Hearing Aid Discount Program		This program provides participants with discounted hearing aids and services throughout the country.			

2024 EPC Benefit Plan Choices offered to *PART-TIME CHURCH STAFF*					
Employees working less than 30 hours per week are not eligible for the Health and Basic Life/ AD&D/LTD Plans.					
	Does your church offer this plan? (Y) or (N)	***Plan types***	***Church Pays %***	***Employee Pays %***	***Comments***
403(b)(9) Retirement Plan (Required for Ordained)		Adoption Agreement (available at *www.epc.org/benefits/2024churchadministratorresources*) needs to be completed and on file with the BRI office. Email completed form to *benefits@epc.org*			
Voluntary Insurance through Colonial Life		**Employee/Dependent Life**			
		Short-Term Disability			
		Accident Coverage			
		Critical Illness Coverage			
Amplifon Hearing Aid Discount Program		This program provides participants with discounted hearing aids and services throughout the country.			

AUTHORIZATION AND SIGNATURE

Name _____

Title _____

Signature_____ Date _____

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BILLING SETUP FORM

To get set up through EPC Billing Administration, please complete and return this form to *benefits@epc.org* or fax to 407-930-4492. This form is for invoicing purposes only.

Church/Organization Name _____ Phone (___)_____

City/State/ZIP _____

Billing Contact Person_____ Phone (___)_____

Billing Contact Email Address _____

Billing Address_____
Street Address

_____
City/State/ZIP (required)

Choose one of the following for enrollment status:

- ☐ New EPC Church (Date Received into the EPC: _____)
- ☐ Existing EPC Church enrolling in coverage for the first time.
- ☐ Pastor Out of Bounds* —*Not Eligible Life or LTD*
- ☐ Retiree Coverage (Pre-Medicare, under age 65 only)* —*Not Eligible Life or LTD*
- ☐ Pastor Without Call* —*Not Eligible Life or LTD*

*EPC presbytery approved ministries only

Effective Date of Coverage _____

Signature of Authorized Church Representative_____ Date_____

..... Presbytery Use Only .....

Presbytery _____

☐ I acknowledge that _____(individual/church) is in good standing with the EPC to enroll/continue coverage in the EPC Benefit Plan under the status noted.

Signature of Authorized Representative_____ Date_____

..... Benefit Resources, Inc., Use Only.....

Signature of Authorized Representative_____

Date_____Customer ID _____

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PARTICIPANT ENROLLMENT/CHANGE FORM

This is a fillable PDF form; save to your computer before completing. Incomplete or unclear information will delay enrollment. Submit completed form to your Church Administrator for processing.

Last Name	First Name	M.I.	Gender	Birthdate	SSN	Daytime Phone

Address	City	State	ZIP

E-Mail Address

Classification:

☐ 1. EPC-Ordained Minister ☐ 2. Other Ordained ☐ 3. Mgmt. (Non-Ordained) ☐ 4. Salaried ☐ 5. Hourly

Job Title:

Reason for Enrollment:

☐ New Hire ☐ Add Dependent ☐ Open Enrollment ☐ Transfer from other Denomination
☐ Transfer from other EPC Church (Previous church:)
☐ Enrollment for loss of other coverage (Attach proof of loss of creditable coverage)

Reason for Change:

☐ Termination of Employment ☐ Death ☐ Address Change ☐ Retirement
☐ Voluntary Termination ☐ Electing other coverage
☐ Transfer to another church (Name/Billing ID of new church:)

List all dependents to be covered by this enrollment

Provide a second form for additional dependents.
(For new dependents, BRI must be notified within 30 days of Qualified Life Event)

	First Name	M.I.	Last Name (if different from Participant)	SSN	Sex	Birthdate
Spouse					☐ M ☐ F	
Dependent					☐ M ☐ F	
Dependent					☐ M ☐ F	
Dependent					☐ M ☐ F	
Dependent					☐ M ☐ F	
Dependent					☐ M ☐ F	
Dependent					☐ M ☐ F	
Dependent					☐ M ☐ F	

Scan and email completed form to *epc@cdsadmin.com* or fax to 412-224-4465

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PARTICIPANT ENROLLMENT/CHANGE FORM

Employee Name _____

Medical/Prescription Drug Plan				I decline Medical/Prescription Drug Plan coverage
☐ Platinum	☐ Single	☐ Couple	☐ Family	☐ EE & Children
☐ Gold	☐ Single	☐ Couple	☐ Family	☐ EE & Children
☐ Gold HDHP	☐ Single	☐ Couple	☐ Family	☐ EE & Children
☐ Silver	☐ Single	☐ Couple	☐ Family	☐ EE & Children
☐ Bronze HDHP	☐ Single	☐ Couple	☐ Family	☐ EE & Children

Dental Plan				I decline Dental Plan coverage
☐ Low Plan	☐ Single	☐ Couple	☐ Family	☐ EE & Children
☐ High Plan	☐ Single	☐ Couple	☐ Family	☐ EE & Children

Vision Plan				I decline Vision Plan coverage
☐ Vision	☐ Single	☐ Couple	☐ Family	☐ EE & Children

Employer-Paid Life/Long-Term Disability (Bundled)
☐ Elect ☐ Decline

Employee Signature _____ **Date** _____

To be Completed by Church Officer (Required for BRI to Process This Form)		
Date of Employee Hire	Effective Date of Enrollment/Change	Employee Annual Salary
Church Customer Number from Invoice (Existing EPC Churches only):		
Church Name (Employer)		
Church City/State/ZIP:	Church Phone:	
Church Officer Name:	Officer Email:	

Church Officer Signature _____ **Date** _____

BENEFICIARY DESIGNATION FORM INSTRUCTIONS

THE HARTFORD

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

The completion of this Beneficiary Form will revoke any previous beneficiary designation(s), if any, for your group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group/employer.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. The listed percentages must add up to 100%. Please provide all of the information requested. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your Company's benefits administrator or your own legal advisor.

A beneficiary for employee Life Insurance may be changed at any time upon written request.

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA).

Sample wording for common beneficiary designations are shown below:

Example #1:

Jane Doe	Relationship: Spouse	Benefit Percentage: 100%

Example #2:

Jane Doe	Relationship: Spouse	Benefit Percentage: 50%
Susan Doe	Relationship: Daughter	Benefit Percentage: 25%
John Does	Relationship: Son	Benefit Percentage: 25%

If additional space is required, write, "See attached", on the beneficiary line on the beneficiary designation form and attach a separate sheet, listing all the required beneficiary information for each beneficiary listed. **This separate sheet should be signed by you (the Employee) and dated.**

BENEFICIARY DESIGNATION

THE HARTFORD

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designation(s) *(check only one box)*, I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group or employer and direct that the insurance proceeds payable under the policy be paid as indicated below.

Employee Name:	Employee ID Number:	Social Security Number: X X X X X ☐ ☐ ☐ ☐
Employee Address:		Telephone Number: ( )
Policyholder/Employer:		Policy Number:

NAMING YOUR GROUP LIFE BENEFICIARY

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact your Company representative or your own legal counsel. Benefits payable for a Dependent's death are payable, where applicable, to You if living, otherwise, We may, at Our option, pay the benefit to Your surviving spouse or to the executors or administrators of Your estate.

PRIMARY BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (___) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (___) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (___) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

CONTINGENT BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (___) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (___) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____ %

Disclaimer: Spousal consent does not apply to ERISA plans.

Spousal Consent For Community Property States Only: If you live in a community property state - Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, or Wisconsin - you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life and/or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: _____ **Date:** _____

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Employee: _____ **Date:** _____

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA)

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PORTAL ACCESS FORM

Church Name_____Date _____

Re: Online Access to Enrollment

To Whom It May Concern:

The EPC Administrative Office is transitioning to an online method of providing groups their monthly invoices, census reports and access to make enrollment changes. In an effort to collect the most current information for your group, please take a moment and complete the sections below and return to our office:

EPC Benefits Administrative Office
60 Boulevard of the Allies, 5th Floor
Pittsburgh, PA 15222

Church Name_____Customer # 06600– _____

Address _____

City_____ State_____ ZIP _____

Billing Contact_____Email_____

Clerk of Session _____Email_____

Additional information will be sent to you in the coming weeks regarding this notice. If you have any questions, please feel free to contact our office at 877-578-8707.

Sincerely,

EPC Benefits Administrative Office