Medical/Prescription Drug Supplement Plan

Use this form to notify the EPC Admin Office of an employee or an employee's dependent(s) who are aging into Medicare and want a Medicare Supplement Plan through the EPC. Scan and email the completed form with the appropriate Certification Form (Small Employer or Large Employer) and a copy of the employee/dependent Medicare card to EPC@cdsadmin.com; fax to 412-224-4465; or mail to EPC Benefits Administration, 60 Boulevard of the Allies, 5th Floor, Pittsburgh PA 15222.

Employee/Dependent Name ______________________________

SSN (Last 4 Digits) ____________________ Birthdate ____________

Effective Date (should match Medicare effective date) ____________________

If Electing Coverage

Please check the box of the Medicare Supplement plan you wish to elect below:

- ☐ Medicare Silver Supplement Plan
- ☐ Medicare Gold Supplement Plan
- ☐ Medicare Platinum Supplement Plan

If you are electing a Medicare plan as the result of your Medicare eligible status but you still have a pre-Medicare dependent (or dependents), your dependent's plan election will not change unless you elect to decline their coverage in the next section.

Employee Signature ____________________ Date ____________

Church Name ____________________ Customer #06606-________

Church Officer Signature ____________________ Date ____________

Email ____________________ Phone ____________

EPC
Benefit Resources, Inc.

List all dependents that should remain covered (if any):

Dependent Name ____

Birthdate ______________________________ SSN (Last 4 Digits)________________

Relationship to Participant____

Dependent Name ____

Birthdate ______________________________ SSN (Last 4 Digits)________________

Relationship to Participant____

Dependent Name ____

Birthdate ______________________________ SSN (Last 4 Digits)________________

Relationship to Participant____

Dependent Name ____

Birthdate ______________________________ SSN (Last 4 Digits)________________

Relationship to Participant____

To terminate any benefits for yourself or your dependents,
continue to the Termination Report Form

TERMINATION REPORT FORM

Use this form to notify the EPC Administration Office of any employee or dependent terminations. Fax the completed form to 412-224-4465, email to EPC@cdsadmin.com or mail to EPC Benefits Administration, 60 Boulevard of the Allies, 5th Floor, Pittsburgh, PA 15222 within 30 days of the termination.

Employee/Dependent name:

Others on policy terminating coverage:

Employee SSN (last four digits): Ordained? ☐ Yes ☐ No

Birthdate:

Effective date of termination Last day of church coverage

Reason for termination:

- ☐ Termination of employment
- ☐ Death
- ☐ Retirement
- ☐ Voluntary termination
- ☐ Transfer to another church
- ☐ Electing other coverage
- ☐ Retirement with other coverage
- ☐ Other (please explain):

Select which benefits you are requesting to terminate:

☐ All benefits ~OR~

☐ Medical ☐ Dental ☐ Vision ☐ Life/Long-Term Disability ☐ Retirement

Employee signature (if available) ____________________

Date

Church name Customer #0660-

Church officer signature ____________________

Date Phone

Email