

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.

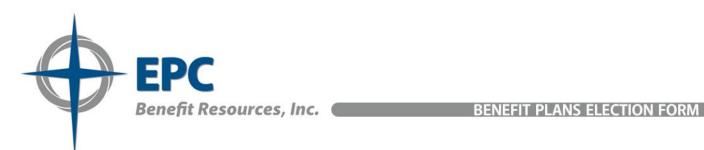
The BRI Team



Please provide information on the 2023 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

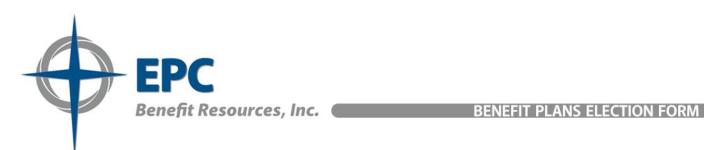
2023 EPC Benefit Plan Choices offered to EPC ORDAINED STAFF						
	Does your church offer this plan? (Y) or (N)	Plan types	Church Pays %	Employee Pays %	Comments	
		Platinum POS				
MEDICAL		Gold POS				
Any combination of Medical Plans		Gold HDHP				
may be offered		Silver POS				
		Bronze HDHP				
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/2023churchadministratorresources) needs to be completed and on file with the BRI office. Email completed form to benefits@epc.org				
		Employee/Dependent Life				
Voluntary Insurance		Short-Term Disability				
through Colonial Life		Accident Coverage				
		Critical Illness Coverage				
Amplifon Hearing Aid Discount Program		This program provides participants with discounted hearing aids and services throughout the country.				



2023 EPC Benefit Plan Choices offered to EPC OTHER STAFF I

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

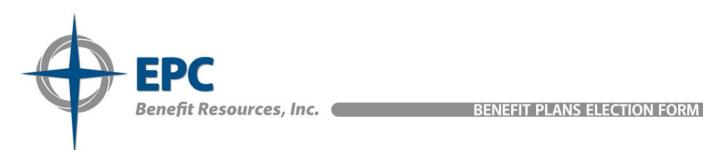
	Does your church offer this plan? (Y) or (N)	Plan types	Church Pays %	Employee Pays %	Comments
		Platinum POS			
MEDICAL		Gold POS			
Any combination of Medical Plans		Gold HDHP			
may be offered		Silver POS			
		Bronze HDHP			
DENTAL		Delta Dental (High Plan)			
DENTAL		Delta Dental (Low Plan)			
VISION		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/2023churchadministratorresources) needs to be completed and on file with the BRI office. Email completed form to benefits@epc.org			
		Employee/Dependent Life			
Voluntary Insurance		Short-Term Disability			
through Colonial Life		Accident Coverage			
		Critical Illness Coverage			
Amplifon Hearing Aid Discount Program		This program provides participants with discounted hearing aids and services throughout the country.			



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

2023 EPC Benefit Plan Choices offered to EPC OTHER STAFF II

	Does your church offer this plan? (Y) or (N)	Plan types	Church Pays %	Employee Pays %	Comments
		Platinum POS			
MEDICAL		Gold POS			
Any combination of Medical Plans		Gold HDHP			
may be offered		Silver POS			
		Bronze HDHP			
DENTAL		Delta Dental (High Plan)			
DENTAL		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/2023churchadministratorresources) needs to be completed and on file with the BRI office. Email completed form to benefits@epc.org			
		Employee/Dependent Life			
Voluntary Insurance		Short-Term Disability			
through Colonial Life		Accident Coverage			
		Critical Illness Coverage			
Amplifon Hearing Aid Discount Program		This program provides participants with discounted hearing aids and services throughout the country.			



2023 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/2023churchadministratorresources) needs to be completed and on file with the BRI office. Email completed form to benefits@epc.org			
		Employee/Dependent Life			
Voluntary Insurance		Short-Term Disability			
through Colonial Life		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	



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)						
Existing EPC Church enrolling inPastor Out of Bounds* —Not Elig	into the EPC:) coverage for the first time. gible Life or LTD , under age 65 only)* —Not Eligible Life or LTD ble Life or LTD					
Effective Date of Coverage						
Signature of Authorized Church Represen	tativeDate					
PresbyteryPres	sbytery Use Only					
	(individual/church) is in good standing in the EPC Benefit Plan under the status noted.					
Signature of Authorized Representative_	Date					
Signature of Authorized Representative						
	Customer ID					

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	
EM IAII							
E-Mail Address							
01 10							
Classification:							
1. EPC-Ordained M	linister 2. Other	Ordai	ned 🗌	3. Mgmt. (No	on-Ordained)	4. Salaried 5. H	lourly
Job Title:							
Reason for Enrollment:							
New Hire	New Hire Add Dependent Open Enrollment Transfer from other Denomination						
	— er EPC Church (Previ	ous ch			_)
	•			oss of credit	able coverage)		,
Enrollment for loss of other coverage (Attach proof of loss of creditable coverage)							
Reason for Change:							
Termination of Em	nployment [] Deat	th	Address	Change	Retirement	
☐ Voluntary Termination ☐ Electing other coverage							
☐ Transfer to another church (Name/Billing ID of new church:							
	<u> </u>						

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						
Dependent						
Dependent						
Dependent						
Dependent						
Dependent						
Dependent					□ M □ F	



			Emplo	yee Name		
Medical/Prescription	n Dave Dles			-l: Ml:	l /n	
Platinum					l/Prescription Drug Plan coverage	
	☐ Single☐ Single	Couple Couple	Family Family		& Children	
	Single	Couple	Family		& Children	
Silver	Single	Couple	Family		& Children	
Bronze HDHP	Single	☐ Couple	Family	EE 8	& Children	
Dental Plan I decline Dental Plan coverage						
Low Plan	Single	Couple	Family		& Children	
High Plan	Single	Couple			& Children	
		douple	ганиу		c Gilliar eli	
Vision Plan			☐ I ded	cline Vision	Plan coverage	
Vision	Single	Couple	Family	EE &	& Children	
				<u> </u>		
Employer-Paid Life	/Long-Term	Disability (Bu	ndled)			
☐ Elect ☐ Decline	!					
Employee Signature					Date	
Employee Signature						
	= -	y Church Office	r (Required f	or BRI to	Process This Form)	
Date of Employe	ee Hire	Effective Date	of Enrollment	:/Change	Employee Annual Salary	
Church Customer Nu	mber from Ir	voice (Existing	EPC Churches	only):		
Church Name (Emplo	yer)					
Church City/State/ZI	P:		Chu	rch Phone:		
Church Officer Name			Offic	cer Email:		
			,			
Church Officer Signat	ture				Date	

BENEFICIARY DESIGNATION FORM INSTRUCTIONS



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

			k only one box), I hereby revoke any HARTFORD h and dismemberment (AD&D) insurance issued to
this group or employer and direct that t			
Employee Name:		oyee ID Number:	Social Security Number:
Employee Address:	'		Telephone Number:
Policyholder/Employer:			Policy Number:
that you name a primary and cor	ary designation be clear so thatingent beneficiary. If you nead the for a Dependent's death a	ed assistance, conta are payable, where	tion as to your intent. It is also important act your Company representative or your applicable, to You if living, otherwise, We 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:%
Louisiana, Nevada, New Mexico, Puerto your spouse to waive his or her rights to consent. Please see your Benefits Adn This will certify that, as spouse of the E beneficiaries of group life and/or accider	operty States Only: If you live in a position of Rico, Texas, Washington, or Wisco any community property interest ininistrator for details. Imployee named above, I hereby contal death insurance under the above. I understand that this consent a	onsin - you may comple in the benefit. Certain trib onsent to my spouse des e policy and waive any ri	tate - Alaska, Arizona, California, Idaho, te the Spousal Consent section, which allows bal jurisdictions may also require spousal signating the person(s) listed above as the insurance may prior spousal consent or waiver under this plan. Date:
I, the undersigned, reserve the righ	t to change the beneficiary(ies)	without the consent of	of said beneficiary(ies)
Signature of Employee:			Date:
Please note that in no event may a ben	eficiary be changed by a Power of	Attorney (POA)	

GR-11927-12 11/2013



PORTAL ACCESS FORM

Church Name		·	Date		
Re: Online Access to Enrollment					
To Whom It May Concern:					
The EPC Administrative Office is transitioning their monthly invoices, census reports and acc to collect the most current information for you the sections below and return to our office:	ess to make e	enrollment o	changes. In an effort		
EPC Benefits Administrative Office 60 Boulevard of the Allies, 5th Floor Pittsburgh, PA 15222					
Church Name		Custo	mer # 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					