

Health Plan Deduction from Benefit Check

Check the applicable box:

- HealthFlex program contribution deduction Non-HealthFlex contribution or premium deductions
-

Part 1 – Participant Information

Participant name _____ Participant # _____

Plan sponsor _____ Social Security # (last 5 digits) _____

Initial deduction

Amount to be deducted per month: \$ _____ Effective date _____

The amount indicated above will be deducted from the benefit check I receive from one or more of the following plans: Clergy Retirement Security Program Defined Benefit (CRSP DB), Ministerial Pension Plan (MPP), Pre-82 Plan, Comprehensive Protection Plan (CPP) and/or Basic Protection Plan (BPP).

Change in deduction

From: \$ _____ to \$ _____ Effective date _____

The new amount will be deducted from the benefit check I receive from one or more of the following plans: CRSP DB, MPP, Pre-82 Plan, CPP and/or BPP.

Comments: _____

Note: When a death occurs, deductions are automatically stopped and will not be transferred to the surviving spouse's record. A new election form for the surviving spouse must be received by Wespath Benefits and Investments (Wespath) to transfer benefits.

Part 2 – Authorization and Release Signatures

I authorize Wespath to deduct the amount(s) I have elected in Part 1 and apply the deductions toward payment of my required contributions or health insurance premiums (contributions) under the terms of the applicable group health plan, either HealthFlex or, as agreed upon between Wespath and annual conference, the health plan maintained by the annual conference. I also authorize Wespath to make changes to these deductions based on any changes in contribution amount due to election changes or otherwise. I acknowledge that I am agreeing to release Wespath, its constituent corporations, directors, officers, attorneys and employees from liability to me, my spouse, my alternate payee, my heirs, named beneficiaries, or successors in interest, for any damages which result from any action or omission taken in reliance on this instrument.

Participant signature _____ Date _____

Plan sponsor signature _____ Date _____

Plan administrator signature _____ Date _____

If you are **NOT** completing this document online, please complete it and return to Wespath by one of the following methods:

- E-mail (scanned copy) to retirementteam@wespath.org or
- Fax to **1-847-866-4677** or
- Mail to Wespath Benefits and Investments
Retirement Benefits
1901 Chestnut Avenue, Glenview, IL60025

Be sure to keep a copy for your records.

This form includes and/or is requesting personally identifiable information (PII) and/or protected health information (PHI). You are encouraged to make elections and beneficiary designations online at benefitsaccess.org. When possible, managing your benefits online is the recommended approach to keep your PII and PHI safe and secure.