GENERAL BOARD OF PENSION AND HEALTH BENEFITS
OF THE UNITED METHODIST CHURCH

Caring For Those Who Serve

1201 Davis Street
Evanston, Illinois 60201-4118
1-800-851-2201
www.gbophb.org

Enrollment Form

United Methodist Personal Investment Plan (UMPIP), Basic Protection Plan (BPP)

Part 1 – Participant Statistical Information. To be completed by the participant or plan sponsor.

Participant name _____ Home phone # (____) _____

Home address _____ Work phone # (____) _____

_____ Spouse name _____

Participant Social Security # _____ Spouse Social Security # _____

Participant birthdate _____ Spouse birthdate _____

Participant gender: ❑ Male ❑ Female Marriage date _____

Part 2 – Employment Information. To be completed by the plan sponsor.

Date of employment _____ Annual compensation* _____

Number of hours regularly worked per week _____

*Please indicate "open" as compensation for hourly employees.

❑ Parsonage provided
❑ Housing allowance amount, if any _____
(Do not include this amount in annual compensation.)
❑ Employee classification, if any _____
(Must match description as entered on UMPIP adoption agreement section 2.3(a) under "Other".)

Part 3 – Reason for Enrollment. To be completed by the plan sponsor.

❑ First-time enrollee (never previously enrolled in any plan)
❑ Addition of a plan
❑ Re-enrollment after previous participation
❑ Transferred from another plan sponsor

Part 4 – Plan Enrollment. To be completed by the plan sponsor.

❑ United Methodist Personal Investment Plan Effective date _____
❑ Basic Protection Plan Effective date _____

Part 5 – Participant Contributions. To be completed by the plan sponsor.

Effective date: _____

The participant completed a *Before-Tax and After-Tax Contributions Agreement* and elected to contribute at the following rates. If the participant fails to complete this form, but you elected Automatic Enrollment on your *UMPIP Adoption Agreement*, insert the before-tax default percentage below. Enter either the percentage or dollar amount, but **not** both.

Before-tax contributions: _____% *or* $_____ per month

After-tax contributions: _____% *or* $_____ per month

(continued)

Part 6 – Plan Sponsor Information. To be completed by the plan sponsor.

Plan sponsor name _____ Employer # _____

Plan sponsor address _____ Phone # (___) _____

Authorized representative _____ Title _____

Authorized signature _____ Date _____

Please mail this original form to the Data Team at the address above. Be sure to keep a copy for your records.
Or, you may fax it to the Data Team at **1-847-866-5195**.