CHURCH BENEFITS BOARD
A MINISTRY OF THE COOPERATIVE BAPTIST FELLOWSHIP
Your benefits are our ministry.

CBF 403(b) Plan
MEMBERSHIP APPLICATION FORM

Church/Employer Acct: New ☐ or #_____

Please check below the participant program enrollment(s), indicate monthly contribution amount or salary annual percentage, and the plan effective date.	**Monthly Contributions**	**Effective Date**
☐ **403(b) Church/Employer Retirement Plan Contribution.** *Employer monthly contribution amount. Employee needs to complete* ***the 403(b) Retirement Beneficiary section below****.*		
☐ **403(b) Employee Deferral Election Contribution.** *Employee elects to defer from each paycheck the following percentage or amount as pre-tax contribution.* ***Complete the CBB SRA Form*** *for payroll processing, see 2nd page for more info on ED Plan*		
☐ **Employee Life, AD&D & Disability Insurance.** *ELIGIBILITY – Enrolled in a CBB 403(b) Account and with taxable benefits working at least 20 hour or per employer policy.* ***Complete the CBB Insurance section below****.*	**3%**	

Note: The effective date can't be prior to the employee's hire date. The first month's premium check will be allocated to the month indicated above.

1- Participant Information

Title	Last Name	First Name	Middle Initial
Home Address		Social Security #	Date of Birth
City / State / Zip		Gender Male ☐ Female ☐	Home Phone
Date of Hire	Job Title	Email	

2- Employment Information

Church or Employer	Administrator Name	Tax ID#
Address	Admin Phone#	Fax#
City / State / Zip	Email	

Are you currently enrolled in a medical plan, or do you intend to enroll following the submission of the Retirement Plan? ☐ Yes ☐ No

For Clergy ONLY: Please indicate ministerial status ☐ Ordained ☐ Commissioned ☐ Licensed

Ordination Status Granted By ☐ CBF church ☐ Other church

For Clergy: Is your employer eligible to designate a portion of your compensation as housing allowance or rental value of parsonage, plus utilities, which would not be reported as taxable income? ☐ Yes ☐ No

3- Compensation Information - REQUIRED TO ENSURE COMPLIANCE WITH IRS REGULATIONS (Calculate carefully; amount is used to ensure compliance with IRS regulations regarding contribution limits).

Compensation Amount (round to the nearest dollar)	**Per Year**	**Year Total**
A) Annual Cash Salary (include amounts to be withheld for per year Employee Payroll Contribution & Flexible Spending Account)		=
B) Clergy Housing (complete either 1 or 2)		
1) Housing Allowance Total or	**1)**	
2) Parsonage rental value		
a) Parsonage allowance	=	
b) Utilities allowance	=	
Total Parsonage (a + b)	**2)**	
Total Housing (select either 1 or 2 amount)		=
C) Social Security/Medicare Tax Offset Amount Should it be included in the premium calculation? ☐ Yes ☐ No		=
D) Total Annual Compensation Amount: (total A + B + C) Does not include life & disability premiums or retirement contribution, medical premiums, or ministry—related exp. such as car exp., continuing education, convention expenses, books, periodicals, etc		=

4- 403(b) Beneficiary Information

STATEMENT OF MARITAL STATUS

☐ **Married Participant Naming Spouse as Sole Beneficiary**	☐ **Married Participant Naming Primary Beneficiary (ies) other than Spouse**	☐ **Unmarried Participant**
By checking this box, I hereby certify to the Church Benefits Board that I am married and intend to name my spouse as the beneficiary of any benefits payable upon my death. (Complete Beneficiary information below)	By checking this box, I hereby certify to the Church Benefits Board that I am married and intend to name my primary beneficiary as someone other than my spouse. (Complete Alternate Beneficiary Designation Form)	By checking this box, I hereby certify to the Church Benefits Board that I am unmarried. (Complete beneficiary information below)

403(b) PRIMARY BENEFICIARY (IES)

Name	Address	SS#	Relationship	% of Proceeds
Name	Address	SS#	Relationship	% of Proceeds
Name	Address	SS#	Relationship	% of Proceeds

* Note: If you are married, Federal Law requires that your spouse be your primary beneficiary unless spousal consent is provided. If you choose someone other than, or in addition to your spouse as primary beneficiary, a signed, notarized Spousal Consent Form must be presented to waive the survivor benefit provided by the Plan. Contact your Plan Administrator should you require a Spousal Consent Form.

403(b) SECONDARY BENEFICIARY(IES

If none of my primary beneficiary(ies) survive me, I designate the following as secondary beneficiary(ies).

Name	Address	SS#	Relationship	% of Proceeds
Name	Address	SS#	Relationship	% of Proceeds
Name	Address	SS#	Relationship	% of Proceeds

If no beneficiary survives me or if no beneficiary is named, my account balance will be payable in accordance with the provisions of the Plan.

I authorize the Plan Administrator to execute my directions as set forth above. I understand these directions will be in effect until a subsequent election is submitted, or as required by law or the Plan. Furthermore, I understand that all benefits and rights to which I am entitled under the Plan will be determined only in accordance with the Plan and Trust Agreement, all amendments thereto, and regulations thereunder. I agree, if more than one beneficiary is designated, payments will be made in equal shares to those persons designated as beneficiaries who survive me, unless indicated otherwise.

403(b) Employee Payroll Election Contributions *(Please complete the Salary Reduction Agreement Form)*

The maximum deferral limits are calendar year limits that include all plans you have participated in during the year is ***$17,000.***

- Participants who will be age 50 or older this year, may elect to make catch-up contributions. You may defer an additional **$5,500** catch-up contribution. Participants must first reach the maximum deferral limits under the regulations or other limits defined by the plan before any catch-up contributions may be made.

☐ By checking this box, I am confirming that I will be age 50 or older this year and would like to make catch-up contributions. Furthermore, I confirm that the 403(b) Employer Payroll deferral election made above includes any amounts that I am permitted to designate as catch up contributions.

5- Insurance Information (complete only if you are enrolling in the CBB Life, AD&D and Disability Insurance)

Let us know how the Insurance Premium payment will be processed:

☐ **Employer/Church -** ***Employer/Church paid***

☐ **Employee Voluntary** ***- Employer paid via Employee Salary Reduction Agreement – Check here if paid with after-tax dollars*** ☐

☐ **Life & Life Dep** ***(after tax)*** **LTD Gross-Up Earnings** ***(pre-tax) - Please*** **contact the CBB office to review this option at** (800) 352-8741.

For Clergy ONLY:

Do you participate in Social Security? ☐ Yes ☐ No, ***Form 4361 filed with IRS***

6- Insurance Primary Beneficiary (ies)

This designation applies to Life/Life with AD&D Insurance available through the Church Benefits Board, if any. Designations are not valid unless signed, dated, and delivered to the Church Benefits Board during your lifetime. See page 2 for further information.

Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Insurance Contingent Beneficiary (ies)				
Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Insurance Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary (ies).
- If you name two or more Beneficiaries in a class:

  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary (ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.

- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated_____ ."

- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.

- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.

- Effective on the 1st of the following month that the employee is approved and for which premiums are paid. The eligible employee shall be enrolled in the CBF-CBB *Group Life*, *AD&D*, *Long Term Disability* and all other insurance and benefit programs available to its eligible employees and their eligible dependents. The effective date of this insurance coverage is intended to be first of the month as outlined above or such other date as the Insurance Companies approve, whichever is later. If approved, no insurance for which evidence of insurability or good health is required will become effective until approved by the Insurance Company at its Home Office.

- The Employer/Applicant authorizes the Church Benefits Board to act as its agent for the purposes set forth in any and all Insurance agreements for the individual named above. This includes functions relevant to the procurement of group insurance policies, including but not limited to: (1) execution of applications for any master group insurance policy (ies); (2) holding any master group insurance policy (ies); and (3) delegation of agency to insurers.

- The Employer/Applicant acknowledges that the master group insurance policy or summary of benefits held by CBB under which insurance is provided may contain numerous optional provisions which are available in order to provide each participating employer with the ability to select provisions which meet its own needs. It is understood and agreed that only those provisions which appear in a Summary of Benefits or certificate provided to the each participating employer apply to such participating employer's insurance coverage, including the Employer/Applicant.

Participation Authorization

I authorize the Church Benefits Board to execute my directions as set forth above.

- I understand these directions will be in effect until a subsequent election is submitted, or as required by law or the Plan.
- I understand that all benefits and rights to which I am entitled under the Plan will be determined only in accordance with the Plan and Trust Agreement, all amendments thereto, and regulations thereunder. I agree, if more than one beneficiary is designated, payments will be made in equal shares to those persons designated as beneficiaries who survive me, unless indicated otherwise
- I understand that my ability to take distributions from my account may be limited.
- I understand my contributions and account balance are automatically invested in the default fund directive, unless I elect to make investment choices.
- I understand that my eligibility for premium-paying membership depends upon my continuing to serve a church or organization appropriately related to the Cooperative Baptist Fellowship, Inc., continuing to serve in ministry as a member ordained by the CBF, and/or continuing to serve in ministry as a member whose ordination is in good standing with CBF.
- I agree to adhere to the provisions and any amendments of said plans for which I apply.
- I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Signature of Applicant	**Date**
Signature of Employer	**Date**

Please keep a copy of this form for your records and return the original to:

Church Benefits Board
2930 Flowers Road, Suite 133A
Atlanta, GA 30341

Phone: (800) 352-8741
Fax: (770) 220-1661
Web: www.churchbenefits.org

CHURCH BENEFITS BOARD
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Primary Beneficiary Designation Form
CBF 403(b) Plan
Spousal Consent Form

PARTICIPANT INFORMATION	
Name	**Social Security Number**

SPOUSAL CONSENT (IF SPOUSE IS NOT DESIGNATED AS THE SOLE BENEFICIARY)

I, the undersigned, being the spouse of the above-named Plan participant, consent to the Non-Spouse Primary Beneficiary designated and to any distribution made pursuant thereto in accordance with the terms of the Plan. I understand that any Plan benefits payable upon the death of the above-named Participant shall be payable to the primary beneficiary(ies) named in the Plan Beneficiary Designation Form in the percentages designated on such form and not to myself, and I hereby consent to the designation and payment to such non-spouse.

Spouse Name	
Spouse's Signature	Date

Notarized by:

Name of Employer or church Administrator SIGNATURE DATE

Please keep a copy of this form for your records and return the original to:

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Atlanta, GA 30341
Web: www.churchbenefits.org

Phone: (800) 352-8741
Fax: (770) 220-1661

CHURCH BENEFITS BOARD
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SALARY REDUCTION AGREEMENT
CBF 403(b) Plan

Employee Information	Check one: ☐ Initial Agreement ☐ Change to Prior Agreement	
Last Name	First Name	M.I.
Social Security No.	Name of Employer	

Salary Reduction Agreement

The employee authorizes the employer to make salary reduction contributions on the employee's behalf to Employee Deferral 403(b) Plan. All such salary reduction contributions shall be forwarded by the employer to The Church Benefits Board (CBB) to be allocated to the employee's Employee Deferral account administered by The Church Benefits Board (CBB). For purposes of making such contributions, the employee agrees that his/her compensation will be reduced as indicated below.

Contribution

1. Deduct From Paycheck: (Select one)

☐ $ _____ per month OR

☐ _____% of base salary amount

Indicate base salary: $ _____ % will change as base salary changes

2. Salary Reductions start with the payroll period beginning:

_____ /_____ /_____

3. Salary Reductions continue: (Select one)

☐ Until I request an end date

☐ Through the last paycheck of the calendar year

☐ For one paycheck only

☐ Until (month/day/year) _____ /_____ /_____

Terms and Conditions

This agreement is legally binding on the undersigned employee and employer, and is irrevocable with respect to compensation earned by such employee while this agreement is in effect. This agreement shall continue until it is terminated or amended. This agreement may be amended, with regard to compensation not yet earned, by the execution of a Salary Reduction Agreement by the employer and the employee no less than 14 days before the start of a payroll period. This agreement supersedes all prior Salary Reduction Agreements and contributions pursuant to this agreement shall immediately cease upon the employee's termination of employment with the employer. If the employee is re-hired, a new Salary Reduction Agreement will be necessary. This agreement may be terminated at any time by the employee for compensation not yet earned, upon written notice delivered by the employee to the employer. A termination request is permanent and remains in effect until a new Salary Reduction Agreement is submitted.

The employee and employer understand that the contributions originate and the tax deferral applies to amounts derived through a reduction of the employee's salary, and the employer forwarding such contributions to CBB. In no event shall these contributions exceed the limits provided by Section 402(g) and/or 415 of the Internal Revenue Code or other applicable limits, which limits are also set forth in the Plan. The employee agrees to promptly notify the employer in the event that these limits are affected by any other plan(s) maintained outside of this employer [for example, a Section 401(k) plan or pension plan] or if he/she has knowledge that they reached any of the foregoing limits. The employer and CBB reserve the right to automatically reduce the amount of the employee's contribution if it is determined that these deductions will exceed any applicable legal limits.

This agreement is not a contract of employment between the employee and the employer, and does not restrict the right of the employer to discharge the employee or the right of the employee to terminate his/her own employment.

Signature of employee	Date
Signature of employer representative	Date

Please return this completed form to:

Church Benefits Board
2930 Flowers Road, Suite 133A
Atlanta, GA 30341

Phone: (800) 352-8741
Fax: (770) 220-1661
Web: www.churchbenefits.org

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APPLICATION FOR ROLLOVER FORM

Cooperative Baptist Fellowship 403(b) Plan
#806561

PARTICIPANT INFORMATION

Title	Last Name	First Name	Middle Initial

Email /phone#	Social Security #	Date of Birth

ROLLOVER CONTRIBUTION INFORMATION

See your Summary Plan Description or Plan Administrator for your plan's rollover provisions. I request the Plan Administrator to accept my rollover, based on the following information. The Plan Administrator reserves the right to require additional evidence that my distribution is from a qualified retirement plan, a tax sheltered annuity, a governmental 457 plan, or an IRA, as allowed by the Plan.

Name of distributing plan or IRA custodian: _____

Amount $ _____ ☐ All Eligible Accounts or ☐ All Total Balance

The requested rollover represents:

a. An eligible rollover distribution from: ☐ a qualified retirement plan ☐ a tax-sheltered annuity ☐ a governmental 457 plan

b. ☐ a distribution from a traditional IRA that would otherwise be includable in my gross income.

a. ☐ a distribution from a Conduit IRA which consisted solely of an eligible rollover distribution from a qualified plan and any associated earnings, for which I wish to preserve capital gains and averaging treatment.

The distribution:

☐ Will be paid directly from the distributing plan to The Standard on behalf of this Plan.

☐ Is from another qualified plan; it includes after-tax contributions of $_____,which must be accounted for separately.

☐ Was paid to me on_____. (The Standard must receive distribution within 60days.)

PARTICIPANT SIGNATURE

I verify that the information provided above is true and complete. I understand that the Plan Administrator may choose not to accept this rollover if it would jeopardize the Plan's tax status. I also understand that if this rollover is accepted, it will be directed to investments based on my contribution directives in place at the time the rollover is received by The Standard. If I do not have directives in place, the rollover will be deposited into the Plan's Default Fund.

Signature of Applicant	**Date**

PAYEE AND MAILING INSTRUCTIONS

The distribution check should be
payable Church Benefits Board FBO: (Participant's Name)
and mailed to: **Church Benefits Board**
2930 Flowers Road, Suite 133A
Atlanta, GA 30341
Attention: Plan No.:806561
Plan Name: Cooperative Baptist Fellowship 403(b) Plan

PLAN ADMINISTRATOR ACCEPTANCE

As an authorized representative of the Cooperative Baptist Fellowship 403(b) Plan, I certify the Plan Administrator has investigated the rollover requested above and is satisfied that it will not jeopardize this Plan's qualified status under the Internal Revenue Code. Therefore, the rollover is accepted, and The Standard is authorized to invest these funds as directed and to establish the appropriate additional accounts for the participant.

Name and Title (please print)	
Signature	**Date**

Please keep a copy of this form for your records and return the original to:

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2930 Flowers Road, Suite 133A
Atlanta, GA 30341

Phone: (800) 352-8741
Fax: (770) 220-1661
Web: www.churchbenefits.org

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Investing Form
CBF 403(b) Plan

YOUR INFORMATION

Social Security Number		Last Name		First Name
Mailing Address		City/State/Zip		
Date of Birth (mm/dd/yy)	Date of Hire (mm/dd/yy)	Phone#	Email address	

WHERE DO YOU WANT TO INVEST YOUR SAVINGS

The Church Benefits Board can help you manage your investments when you select a Guided Portfolio or you may also create your own Independent Portfolio. If you do not indicate where to invest your savings, your assets will be placed in the plan's default fund(s). The decisions you make regarding your investments will stay in effect until you modify them via The Standard's Web site at (**http://retirement.standard.com**) or via INFOLINE (**800.858.5420**). ***Select only one box*** of the Guided Portfolios below, OR select your own investments by entering whole percentages in the "**Independent**" column. Be sure that your selections total 100% and that the minimum any investment is 1%. This investing Form is to be used ONLY by eligible plan participants. To make changes to your current investment directive, visit (**http://retirement.standard.com**) or via INFOLINE (**800.858.5420**).

		Choose ONE Guided Portfolio OR create your Independent Portfolio					
Fund Name	**Style**	☐ Conservative	☐ Moderately Conservative	☐ Moderate	☐ Moderately Aggressive	☐ Aggressive	☐ **Independent**
Cash Equivalent		**30%**	**20%**	**10%**	**0%**	**0%**	
The Standard Stable Asset A	Stable Value	30%	20%	10%	0%	0%	%
Bonds		**50%**	**40%**	**30%**	**20%**	**0%**	
Metropolitan West TotRe Bd I	Intermed-term Bond	50%	40%	30%	20%	0%	%
Vanguard Inflat Prot Sec Adm	Intermed-term Bond	0%	0%	0%	0%	0%	%
Equities							
Large Cap Stock		**13%**	**26%**	**39%**	**52%**	**65%**	
Vanguard 500 Index Signal	Larger	7%	13%	19%	26%	33%	%
JPMorgan Large Cap Grwth R6	Larger Growth	3%	7%	10%	13%	16%	%
Vanguard Windsor II Admiral	Larger Value	3%	6%	10%	13%	16%	%
Neuberger Berman Soc Res Inv	Larger Blend	0%	0%	0%	0%	0%	%
Mid/Small Cap Stock		**4%**	**8%**	**12%**	**16%**	**20%**	
Neuberger Berman Md Cp Gr Inv	Mid-Cap Growth	1%	2%	3%	4%	5%	%
Columbia Mid Cap Val Opp R4	Mid-Cap Value	1%	2%	3%	4%	5%	%
Columbia Small Cap Value II Z	Small Value	2%	4%	6%	8%	10%	%
Alger Small Cap Growth Institutional	Small Growth	0%	0%	0%	0%	0%	%
International Stock		**3%**	**6%**	**9%**	**12%**	**15%**	
Thornburg International Value R5	Foreign Stock	3%	6%	9%	12%	15%	%
Other							
DFA Emerging Mrkts Core Eq I	Diversified EmergMrkts	0%	0%	0%	0%	0%	%
Vanguard Wellington Inv	Mod Allocation	0%	0%	0%	0%	0%	%
Vanguard Balanced Indx Signl	Mod Allocation	0%	0%	0%	0%	0%	%
	Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

AUTOMATIC REBALANCER

Check a box below to select the Automatic Rebalancer service for your Plan account. If you select this service, your account assets will be rebalanced to match your investment directives at the time of rebalancing. Automatic Rebalancer will remain off if you do not make a selection below.

How often would you like your account rebalanced? ☐ **Quarterly** ☐ **Semiannually** ☐ **Annually**

AUTHORIZATION

I authorize my employer and the plan administrator to invest my savings as outlined on this form. I also direct my employer and the plan administrator to implement any other instructions I have provided on this form. I have read the Disclosure Statement on this form and, by signing here, I agree to be bound by its terms. The employer, trustees and any others concerned with the administration of the Plan are entitled to rely on these instructions; each shall be fully protected in taking or omitting any action under any provisions of the Plan in reliance on this information.

Participant Signature	Date

Disclosure Statement: You must notify The Standard within 15 days of receipt of your quarterly account statement if an error occurred, or if you requested and confirmed an investment transfer or directive change that was not completed during the period covered by the statement. You may give notice by contacting a customer service representative at **800.858.5420** or by e-mailing **savings@standard.com**. Unless you give such notice, The Standard will not be liable for any resulting loss to your account. In any case, The Standard will not be liable if circumstances beyond its control prevent the transaction, or if its liability is otherwise limited by regulation or agreement.

Please keep a copy of this form for your records and return the original to:

Church Benefits Board, 2930 Flowers Road, Suite 133A, Atlanta, GA 30341 Phone: (800) 352-8741 Fax: (770) 220-1661