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

EMPLOYMENT CHANGE FORM
CBF 403(b) Plan

CBB Acct#_____

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- Previous Employment Information (Please complete if you are terminating employment with this employer)

Church or Organization	Employer/Administrator Phone	Salary Termination Date
Address	Administrator Name	
Town/City State Zip Code	If enrolled in Life & LTD Insurance please provide the last date your former employer will paid your premium:	

☐ I am in or will be entering full-time graduate study and plan to seek placement within the Cooperative Baptist Fellowship, Inc. (CBF) after I complete my studies.

☐ I am temporarily without work that is an exercise of my ministry but seeking placement within CBF or exercising my ministry in another setting.

☐ I am now employed with the following employer. (Please complete the current employer section)

3- Current 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

Eligibility - Please complete only if an employer is not related to CBF.
Check all that apply.

☐ **I was ordained, commissioned or licensed as a minister by a church in _____ (denomination) in _____ (year).**

☐ **I was ordained, commissioned or licensed as a minister by a church not related to CBF, but my ministry status currently is recognized by CBF.**

☐ **I consider my new position as an exercise of my ministry.**

☐ **I am endorsed as a military chaplain, institution chaplain or pastoral counselor by National Ministries or CBF.**

4- 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		=

5- 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.

6- 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***

7- 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

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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

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