Pension Fund of the Christian Church

TAX-DEFERRED RETIREMENT ACCOUNT (TDRA) ENROLLMENT FORM

- PLEASE TYPE OR PRINT CLEARLY -

I. APPLICANT INFORMATION

Full Legal Name ____
(first, middle, last/family name)

Title Preference: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Rev. ☐ Dr. ☐ Chap. ☐ None

Social Security No./ITIN _______ - _____ - _________ Date of Birth ________/________/________ Gender: ☐ M ☐ F

Home Address ____

City ______________________ State ______________ Country __________ Zip ________-______

Home Phone (_______) ____________ Work Phone (_______) ____________ Cell Phone (_______) ____________

E-Mail Address ____

US Citizen (*check one*): ☐ Yes ☐ No, citizen of ______________________ ***If you are not a US citizen, you must have an ITIN to enroll.***

If Minister, check one: ☐ Ordained ☐ Commissioned ***IMPORTANT: Please provide a copy of your current credentials with this Form.***

Date of ordination or first date of commission is ________/________/________.

II. EMPLOYMENT INFORMATION

Employer ______________________________________ Date of Employment ________/________/________

Mailing Address ____

City ______________________ State ______________ Country __________ Zip ________-______

Contact Name ____

Phone (_______) ______________ E-Mail Address ______________________________

Applicant's Position ____
(Minister, Associate Minister, Educator, Administrative Assistant, Health Care Professional, Custodian, etc.)

III. CONTRIBUTION INFORMATION

The initial contribution amount remitted to the TDRA on behalf of the applicant is $______________________. This contribution amount reflects the following:

☐ $________________ in pre-tax contributions ***IMPORTANT: Please provide an executed Salary Contribution Agreement with this Form.***

☐ $________________ in Employer contributions

IV. DESIGNATION OF BENEFICIARIES

Designate the person, trust or entity you choose to receive any benefits payable from your 403(b) account under the TDRA in the event of your death. If you designate a trust as a beneficiary, include the trust's name and address, the date the trust was created, and the trustee's name. You are not limited to three primary and three contingent beneficiaries. To designate additional beneficiaries, please attach and sign a separate piece of paper.

Unless otherwise indicated, death benefits will be paid in equal shares to your primary beneficiaries who are living at the time of your death. If no primary beneficiary is living at your death, unless otherwise indicated, death benefits will be paid in equal shares to your contingent beneficiaries who are living at the time of your death. If you name multiple primary or contingent beneficiaries, and one of them predeceases you, the percentage of that beneficiary's designated share shall be divided equally among the surviving primary or contingent beneficiaries, as applicable.

IMPORTANT: If you do not elect a beneficiary, or if your beneficiaries named on this Enrollment Form fail to survive you, your benefits will be paid to your spouse, or if none, your benefits will be paid to your estate. Failure to include a social security number for each designated beneficiary, if applicable, may delay distributions at your death.

Primary Beneficiaries ***The total percentage to all primary beneficiaries must equal 100%.***	**Percentage of Benefit**
Individual or Trust Name ______________________________ (first, middle, last/family name) Mailing Address ______________________________ (street, city, state, zip) Primary Phone (________) ______________ Relationship to Applicant/Trustee Name ______________ Social Security No./ITIN _______ - _____ - _________ Birth or Trust Date ________/________/________	__________%
Individual or Trust Name ______________________________ (first, middle, last/family name) Mailing Address ______________________________ (street, city, state, zip) Primary Phone (________) ______________ Relationship to Applicant/Trustee Name ______________ Social Security No. _______ - _____ - _________ Birth or Trust Date ________/________/________	__________%
Individual or Trust Name ______________________________ (first, middle, last/family name) Mailing Address ______________________________ (street, city, state, zip) Primary Phone (________) ______________ Relationship to Applicant/Trustee Name ______________ Social Security No. _______ - _____ - _________ Birth or Trust Date ________/________/________	__________%

Contingent Beneficiaries If all of your primary beneficiary(ies) die before you, any benefits payable in the event of your death will be paid to your contingent beneficiary(ies). ***The total percentage to all contingent beneficiaries must equal 100%.***	**Percentage of Benefit**
Individual or Trust Name ______________________________ (first, middle, last/family name) Mailing Address ______________________________ (street, city, state, zip) Primary Phone (________) ______________ Relationship to Applicant/Trustee Name ______________ Social Security No./ITIN _______ - _____ - _________ Birth or Trust Date ________/________/________	__________%
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Individual or Trust Name ______________________________ (first, middle, last/family name) Mailing Address ______________________________ (street, city, state, zip) Primary Phone (________) ______________ Relationship to Applicant/Trustee Name ______________ Social Security No./ITIN _______ - _____ - _________ Birth or Trust Date ________/________/________	__________%

V. SPOUSAL CONSENT

If you reside or have resided in a community or marital property state (which may include, but are not necessarily limited to, AZ, CA, ID, LA, NV, NM, PR, TX, WA, and WI) and you are married, your spouse may need to complete this Section V in order for you to name any one other than, or in addition to, your spouse as a beneficiary. If you are not currently married and you become married in the future, you must complete a new Beneficiary Designation Form. It is your responsibility to determine if this Section V applies and to determine if the spousal consent language below is sufficient to satisfy applicable state statutes. **Your state may require this Enrollment Form to be signed in the presence of a Notary Public.**

SPOUSAL CONSENT. I am the spouse of the applicant. Due to the important tax consequences of giving up my interest in the funds covered by this beneficiary designation, I have been advised to see a tax or legal professional. I hereby voluntarily and irrevocably give the applicant any community property or marital interest I have in the funds covered by this beneficiary designation and consent to the beneficiary designation(s) indicated above. I assume full responsibility for this consent.

Spouse Signature ______________________________ **Date** _______/_______/_______

Print Name ______________________________

Please have completed if your spouse's signature must be acknowledged by a Notary Public:

STATE OF ___________________________)
COUNTY OF _________________________)

On this _________ day of _____________, personally appeared before me the above named______________________________, personally known to me, who, being duly sworn, deposes and says that he or she executed the foregoing consent.

Notary Public Signature ______________________________ **My commission expires** ________/________/________

VI. APPLICANT CERTIFICATION AND SIGNATURE

In signing this Enrollment Form, I agree to be bound by all terms of the TDRA, as it may be amended from time to time, and all administrative policies and procedures adopted by Pension Fund with respect to the TDRA. I understand that I will be mailed a copy of the Tax-Deferred Retirement Account Member Resource Book upon Pension Fund's receipt of this Enrollment Form, and that I can also access the Member Resource Book and other information regarding the TDRA electronically at www.pensionfund.org.

I certify that the information provided on this Enrollment Form is accurate. **I agree that I will timely notify Pension Fund of any changes to the information provided on this Form, including when employment is severed with my Employer.**

I understand that in order to make salary reduction contributions to the TDRA, I must first complete and submit a separate Salary Contribution Agreement to my Employer which directs my Employer to reduce my salary by a stated dollar amount or percentage each pay period and to contribute such amount or percentage to the TDRA.

I designate the person(s) or entity(ies) named in Section IV of this Enrollment Form as beneficiaries for my 403(b) account under the TDRA. I reserve the right to revoke this designation at any time by submitting a new Beneficiary Designation Form. I understand that my beneficiary designation on this Enrollment Form will remain in effect until I complete, sign, and submit an updated Beneficiary Designation Form to Pension Fund at a later date. I certify that I have secured spousal consent if I have named a beneficiary other than, or in addition to, my spouse to the extent I reside in a community or marital property state and am required to secure such consent by state law with respect to all or a portion of my 403(b) account. I assume complete responsibility for all consequences if I fail to obtain any required consent.

Applicant Signature ______________________________ **Date** ________/________/________

VII. EMPLOYER CERTIFICATION AND SIGNATURE

I certify that I am authorized to sign this Enrollment Form on behalf of the Employer of the applicant. I certify either that a Participation Agreement has already been submitted on behalf of the Employer or is being submitted contemporaneously with this Enrollment Form, and that the applicant is eligible to participate in the TDRA under the terms of the TDRA and the Participation Agreement.

I certify that payment for an initial contribution on behalf of the applicant, as set forth in Section III, is enclosed with this Form. If the applicant has entered into a Salary Contribution Agreement with the Employer, I am submitting a copy of this Agreement contemporaneously with this Enrollment Form. I further agree to submit any revisions to the Salary Contribution Agreement to Pension Fund on or before such revisions become effective.

I further agree to notify Pension Fund immediately if the applicant terminates employment with the Employer.

Employer Representative Signature ______________________________ **Date** ________/________/________

Print Name ______________________________

SEND FORM WITH INITIAL CONTRIBUTION AND RELATED FORMS, IF APPLICABLE, TO:

Pension Fund of the Christian Church
P.O. Box 6251, Indianapolis, Indiana 46206-6251
Toll Free: 1.866.495.7322 • Phone: 317.634.4504 • Fax: 317.634.4071
E-mail: pfcc1@pensionfund.org • Website: www.pensionfund.org

Membership No. _____________________ **PIN No.** ___________________________ **Enrollment Date** ________/________/_______

Initial Contribution Amount Remitted $__________________________________

[Do not write in this box – for Pension Fund use only]