

Form C – Clergy Disability Benefits Application: Initial Continuance

Applicant Instructions

- Complete Part 1
- Read Part 2
- Sign Part 3
- Sign Part 4
- Sign authorization on page 3

Part I – Applicant Information. Your application for disability cannot be reviewed until this form is completed.

Applicant name _____ Participant # _____

Present address _____ Social Security # _____

_____ Applicant birth date _____

Primary phone # (____) _____ Alternate phone # _____

Country of citizenship _____

Future address _____ As of date _____

_____ New primary phone # (____) _____

Conference/Plan sponsor (name and conference or employer #) _____

Part 2 – Explanation of Plan Provisions

1. The granting of disability benefits from the Comprehensive Protection Plan is subject to:
 - a determination that the applicant is eligible to receive benefits under the terms of the Comprehensive Protection Plan if applicable, and
 - receipt and review of medical evidence sufficient to support the claim of a disabling condition by Wespath Benefits and Investments (Wespath).
2. Comprehensive Protection Plan disability benefits shall begin only on the first day of the month for which the applicant did not receive salary.
 - No disability benefits shall be payable on a retroactive basis for any period of time in excess of 365 days from the date the payment of disability benefits is approved.
3. When a clergy member is granted medical leave by the bishop, if the medical evidence has not yet met the standards for receipt of disability benefits as set forth in the Comprehensive Protection Plan, section 5.04, the Conference Board of Pensions may authorize payment of the disability benefits in the amount that would otherwise be payable from the Comprehensive Protection Plan. The payments shall be made by Wespath as a charge to the annual conference granting the medical leave. If payments from the Comprehensive Protection Plan are subsequently approved, the annual conference will be reimbursed for benefits already paid, not to exceed the amount otherwise payable from the Comprehensive Protection Plan (*The Book of Discipline*, ¶1357).
4. The actual terms, conditions, benefits and limitations of the Comprehensive Protection Plan are contained in the plan document. Please consult the summary plan description for details.

Part 3 – Applicant Signature. To be completed and signed by the applicant.

I, by reason of a bodily injury, disease, or behavioral illness or disorder, for at least six continuous months, am unable to perform the usual and customary duties of a United Methodist clergyperson. **I became, or anticipate becoming, unable to perform the usual and customary duties of my job on or about (date)** _____. I hereby apply for disability benefits in accordance with the provisions of the Comprehensive Protection Plan.

Applicant signature _____ Date _____

Part 4 – Signatures

I have read the information and notes on page 1, and acknowledge that the individual named is applying for disability benefits under the terms of the Comprehensive Protection Plan.

District superintendent _____ Date _____

Conference benefits officer _____ Date _____

Chair Joint Committee on Clergy Medical Leave

_____ Date _____

When signed and dated, this application form should be submitted promptly to:

Disability Benefits Administrator
Wespath Benefits and Investments
1901 Chestnut Avenue
Glenview, Illinois 60025

Authorization to Release Information to Wespath Benefits and Investments (Wespath)

This authorization for release of information is to any licensed physician or health care provider; any hospital, medical clinic or pharmacy; any employer; any insurance or reinsurance company, or workers' compensation carrier; any organization, governmental agency or institution administering a benefit program; any educational, vocational and rehabilitation institution or program.

The signatory, by signing this document, hereby authorizes you to furnish Wespath Benefits and Investments (Wespath), Incorporated in Illinois, any and all records concerning the signer's physical and mental condition and medical history, including but not limited to diagnosis, prognosis, treatment, recommendations for treatment, and periods of education, training, experience and employment, including but not limited to dates of employment, compensation, job description and any records and information concerning benefits which the signer is receiving or to which he or she may be entitled. For purposes of this release, Wespath includes the company, its authorized agents, benefit plans administrator, HIPAA business associates and consultants.

It is understood that these records may contain information regarding the diagnosis or treatment of HIV (AIDS virus) or other sexually transmitted diseases, drug and alcohol abuse, mental illness or psychiatric treatment and that specific authorization for these records to be released is granted by this signature.

It is understood that Wespath will use the information collected to determine eligibility for benefits under the Comprehensive Protection Plan, United Methodist Personal Investment Plan, Clergy Retirement Security Program, Retirement Plan for General Agencies and any other relevant plans administered by Wespath.

An exact authentic photocopy of this authorization shall be as valid as the original.

It is understood and agreed that this authorization shall remain in force throughout the duration of the claim and payment of benefits under the disability and pension plans administered by Wespath.

Name _____ Primary phone # (_____) _____

Signature _____ Date _____

Address _____
