

LIFE & DISABILITY INSURANCE APPLICATION FORM



Life Insurance Company of North America (LINA)
 a CIGNA Company (herein called the Insurance Company)
 For info and customer service call 1-800-732-1603.

• The applicant must sign and date this form.

EMPLOYER:	ORTHODOX HEALTH PLANS
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Important: Please enter all dates in mm/dd/yyyy format. Please print (preferably in black ink)

EMPLOYEE SECTION

Mr. Mrs. Ms. (Check One)

Employee Name _____ Social Security # _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Date of Hire _____ Work Phone _____ Home Phone _____ Sex: M F

TERM LIFE INSURANCE – POLICY NO. FLX-968424
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Applicant's Name _____ Social Security # _____

BENEFICIARY DESIGNATION

To specify a beneficiary, complete the section below. You will be the beneficiary for your spouse and child(ren) unless you specify otherwise. When specifying multiple beneficiaries, you must indicate the percentage of distribution for each. If there is not enough room to specify all beneficiaries, attach, sign and date a separate sheet of paper using the format below.

TERM LIFE INSURANCE – POLICY NUMBER FLX-968424					
Employee Name	Beneficiary	Percentage	Social Security #	Date of Birth	Relationship

Community Property Laws – If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary, payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.

Spouse Signature _____ Date _____

Owner Signature _____ Date _____

GUIDELINES FOR DESIGNATION OF BENEFICIARIES

General – Please be sure to include the beneficiary’s full name, social security number and relationship to you. Providing this information can help expedite the claim process by making it easier to locate and verify beneficiaries.

Minors - While you may designate minors as beneficiaries, please note that claim payments may be delayed due to special issues raised by these designations. In the event of a claim and the beneficiary is a minor child, the insurance proceeds will not be released to the minor child. The insurance proceeds may be paid to a duly appointed guardian of the child’s estate. You may want to obtain the assistance of an attorney in drafting your beneficiary designation.

Trust as Beneficiary - You may designate a trust as beneficiary, using the following form: “To [name of trustee], trustee of the [name of trust], under a trust agreement dated [date of trust].”

If you wish to designate a testamentary trust as beneficiary (i.e., one created by will), you should recognize the possibility that your will, which was intended to create this trust, may not be admitted to probate (because it is lost, contested, or superseded by a later will). Claim payment delays can result if the beneficiary designation doesn’t provide for this situation.

Life Status Changes - We recommend that you review your beneficiary designation when significant life status events occur, such as marriage, divorce, or birth of a child.

See an Attorney! The above guidelines are general and are not intended to be relied on as legal advice. Unless your designation is a simple one, we recommend that you obtain the assistance of an attorney in drafting your beneficiary designation. A qualified attorney can help assure that your beneficiary designation correctly reflects your intentions, is clear and unambiguous, and meets legal requirements.

Return this form to your employer. Be sure to make a copy for your own records.

BENEFICIARY DESIGNATION FORM
 Life Insurance Company of North America



Employer Name ORTHODOX HEALTH PLAN / ANTIOCHIAN ORTHODOX CHRISTIAN ARCHDIOCESE
 Employee Name _____ Employee Social Security # _____
 Current Address _____ City _____ State _____ ZIP _____
 Home Phone _____ Work Phone _____ *please enter all dates in mm/dd/yyyy format*

Primary and Contingent Beneficiaries – Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares. Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

If you want to designate the same beneficiary(ies) for all listed plans that apply to you, indicate the named beneficiary(ies) in the section below and check this box.

Basic Term Life Insurance, Life Insurance Company of North America - Policy No. FLX968424				
Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Address:			Phone Number:	
Address:			Phone Number:	
Employee's Contingent Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Address:			Phone Number:	
Address:			Phone Number:	

Basic Accident Insurance, Life Insurance Company of North America - Policy No. OK969910				
Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Address:			Phone Number:	
Address:			Phone Number:	
Employee's Contingent Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Address:			Phone Number:	
Address:			Phone Number:	

If you need additional space using the above format, attach a separate piece of paper with the appropriate policy number, the date, and your signature.

Note: This form is not complete without your signature. Please sign the form where indicated.

Community Property Laws - If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary, it is possible that payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.

Spouse Signature _____ Date ____/____/____

Owner Signature _____ Date ____/____/____

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See an Attorney! The above guidelines are general and are not intended to be relied on as legal advice. Unless your designation is a simple one, we recommend that you obtain the assistance of an attorney in drafting your beneficiary designation. A qualified attorney can help assure that your beneficiary designation correctly reflects your intentions, is clear and unambiguous, and meets legal requirements.

January 10, 2014
Saint Gregory of Nyssa

Beloved Brothers in Christ,

Greetings in the Name of our Lord Jesus Christ!

The Department of Clergy Insurance and Retirement has taken some initiatives with the approval of the Metropolitan Archbishop and the Archdiocese Board of Trustees to bolster the Retired Clergy Housing Allowance (RCHA).

First, we will freeze all “entitlements” earned by our clergy through their years of service at the level of January 1, 2013, the date on which the new Defined Contribution Plan went into effect. Please keep in mind that this allowance remains non-contributory and is awarded solely at the discretion of the Metropolitan who grants retirements.

Second, we are purchasing a new insurance policy on all our clergy for \$40,000 **at no additional cost to the clergy or the parishes**; however, this additional coverage will flow back into the RCHA fund and not to the insured in order to extend the useful life of the fund. This action requires that all clergy complete the enclosed Beneficiary Designation form in the highlighted areas and return the completed form **no later than February 17, 2014** to:

The GDC Financial Group, Inc.
929 Kings Highway East
1st Floor
Fairfield, CT 06825
Attn: Antiochian Archdiocese RCHAF

By signing this form, you name the Retired Clergy Housing Allowance Fund as the beneficiary for this new policy. Please note that your beneficiary for the life insurance policy which is already in place (the one that is funded by your parish’s payment of \$75.00 per month) will not be affected.

We will continue to monitor the state of the RCHA and take appropriate action as necessary in the future in order to keep our moral commitment to the clergy to provide this housing stipend. If you have any questions, please contact either Fr. Michael Ellias, Chairman of the Department, at (718) 238-8008 or smaoc@earthlink.net, or Fr. George Kevorkian, the Metropolitan’s Hierarchical Assistant, at (201) 871-1355 or frgeorgek@antiochian.org.

In Christ,

The Department of Clergy Insurance and Retirement
Antiochian Orthodox Christian Archdiocese of North America

The GDC Financial Group, Inc.

BENEFICIARY DESIGNATION FORM
 Life Insurance Company of North America



Employer Name ORTHODOX HEALTH PLAN / ANTIOCHIAN ORTHODOX CHRISTIAN ARCHDIOCESE
 Employee Name _____ Employee Social Security # _____
 Current Address _____ City _____ State _____ ZIP _____
 Home Phone _____ Work Phone _____ *please enter all dates in mm/dd/yyyy format*

Basic Term Life Insurance, Life Insurance Company of North America - Policy No. FLX968424				
Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
RETIRED CLERGY HOUSING FUND	N/A	11-6007930	N/A	100%
Address: 358 Mountain Road Englewood NJ 07631			Phone Number: 201-871-1355	

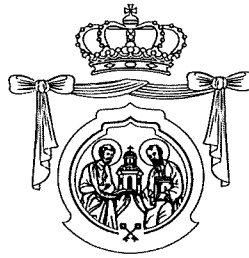
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Spouse Signature _____ Date ____/____/____

Owner Signature _____ Date ____/____/____

His Eminence
The Most Reverend
Metropolitan JOSEPH



Archbishop of New York and
Metropolitan of
All North America

**ANTIOCHIAN ORTHODOX CHRISTIAN ARCHDIOCESE
OF NORTH AMERICA**

March 7, 2019

The Holy Martyred Bishops of Cherson: Basileus, Ephraim, Eugene, Capito, Aetherius,
Agathodorus, and Elpidius

Greetings in the Name of Our Lord, God, and Savior Jesus Christ,

The Department of Clergy Insurance and Retirement has addressed one of the recommendations our clergy and parishes have made. We are pleased to announce a new automated payment system for the Life and Disability Insurance Plan. This system will improve the process of submitting premium payments and will save parishes and the Archdiocese time and effort.

Similar to the newly implemented 401(k) e-payments, each parish and participating priest is asked to complete the attached authorization form. This procedure will allow the Archdiocese to debit the premium of \$135 every 15th of the month¹ beginning April 15, 2019.

The deadline to submit the signed form is Monday, March 18, 2019 – NO EXCEPTIONS. Kindly read the authorization form carefully for instructions on submitting a voided check.

If you have any questions, please contact Marlene Ayoub at the Archdiocese by calling (201) 871-1355 or emailing registrar@antiochian.org.

With prayers for an edifying and fruitful Great Lent,

In Christ,

The Department of Clergy Insurance and Retirement
Antiochian Orthodox Christian Archdiocese of North America

¹ Please note that this rate only applies to the year 2019. By signing above, you agree to any future changes of the rate in the coming years.

“The disciples were first called Christians in Antioch” (Acts 11: 26)

358 Mountain Road, P.O. Box 5238, Englewood, NJ 07631-5238
(201) 871-1355 T Archdiocese@antiochian.org (201) 871-7954 F

His Eminence
The Most Reverend
Metropolitan JOSEPH



Archbishop of New York and
Metropolitan of
All North America

ELECTRONIC FUNDS TRANSFER AUTHORIZATION FORM

Life and Disability Insurance Premium Electronic Payment

We, the faithful of would like to participate in the electronic payment for the life and disability of our pastor. Please select one of the following options:

- We have attached a **voided blank check**. *(If so, please proceed to fill out sections 1 through 4.)*
- We allow the Archdiocese to use our previously submitted information, through the 401K e-payment.
(If so, please proceed to fill out sections 1, 2 and 4 ONLY.)

1 - Parish Information:

Name of Parish *(As appearing on the Bank Account)*

Address: City: State: Zip:

Email: Phone:

2 - Pastor's Information:

Full Name: *(official name as on driving license)* Name: *(if different than driving license)*

Address: City: State: Zip:

Email: Phone:

3 - Bank Account Information: *(Please attach a voided check)*

Bank:

Routing Number: Account Number: Checking Account OR Saving Account

Amount deducted monthly for this year of 2019*: \$135 *(15th of month)*

The deduction of funds will occur on the 15th of each month.

4 - Signature:

Name and Signature of Parish Council Chairperson:

Name and Signature of Parish Council Treasurer:

Name and Signature of Pastor:

Administrator: *(for Plan administration only)*

Date/Time

*Please note that this rate only applies to the year 2019. By signing above you agree to any future changes of the rate in the coming years.