

# SEVENTH-DAY ADVENTIST RETIREMENT PLAN

for North America

12501 Old Columbia Pike, Silver Spring MD 20904-6600

Phone 301-680-6249; Fax 301-680-6190

Website [www.nadadventist.org/ret](http://www.nadadventist.org/ret)

## CHURCH PLAN APPLICATION

### Type of Application

(Indicate one box:)

Regular Benefits

Date of Application

August 7, 2006

Survivor Benefits

Date of Death

Name	Gender	Date of Birth	NRA NRD
------	--------	---------------	------------

Address 1	Phone #	Social Security #
-----------	---------	-------------------

Address 2	<b>SERVICE CREDIT (SC) AND BENEFIT RATE FACTOR (BRF) COMPUTATIONS TO BE COMPLETED BY EMPLOYER.</b>
City/State/Zip	

### SERVICE CREDIT

SERVICE CREDIT												10 High Years	Remun %	Yearly Rate Factors
Years	Church	Hospital	Canada	Years	Church	Hospital	Canada	Years	Church	Hospital	Canada			
1963				1978				1993						
1964				1979				1994						
1965				1980				1995						
1966				1981				1996						
1967				1982				1997						
1968				1983				1998						
1969				1984				1999						
1970				1985				2000						
1971				1986				2001						
1972				1987				2002						
1973				1988				2003					BRF:	0.00
1974				1989				2004				<b>SC Breakdown</b>		
1975				1990				2005				Church	0.00	
1976				1991				2006				Hospital	0.00	
1977				1992				2007				Canada	0.00	
<i>Adjust</i>				<i>Adjust</i>				<i>Adjust</i>						
<i>Sub Total</i>	0.00	0.00	0.00	<i>Sub Total</i>	0.00	0.00	0.00	<i>Sub Total</i>	0.00	0.00	0.00	<b>Total SC</b>	<b>0.00</b>	

Explanatory Notes:

License or Credential Presently Held by Employee:	Current Marital Status (Type one): <i>Single, Married, Divorced, Separated, Widowed</i>
---	--

Has Employment Ceased? Yes/No:	If Yes, date:	Type Reason -- Age, Disability Other (explain):
--------------------------------	---------------	---

Cessation from Employment is considered (type one) <i>Temporary/Permanent:</i>	Have you applied to Social Security for disability? <i>(Type Yes or No)</i>	If Yes, date:
---	--	---------------

**SPOUSE INFORMATION** (Required regardless of eligibility for Spouse Allowance or Joint & Survivor Annuity.)

Name of Spouse	Date of Birth	Date of Marriage	SS #
----------------	---------------	------------------	------

Is your spouse employed an average of 30 hours per week or more? <i>Type Yes or No:</i>	Name of Employer
---	------------------

**Single Life Benefit** — I wish to waive the joint survivors benefit and elect the single life: *Type Yes or No:* **If "Yes" both you and spouse must sign the waiver form.**

Is your spouse receiving benefits from SDA Retirement Plan? <i>Type Y or N</i>	Will spouse apply for SDA Ret. benefits later? <i>Type Yes or No:</i>
--	---

Spouse Allowance Application? <i>Requires 20+ years of service credit. Type Y(es) or N(o):</i>	Is spouse receiving a pension now? <i>Type Y(es) or N(o):</i>	Or will be eligible in the future? <i>Type Yes or No:</i> If Yes, please notify the retirement office when spouse's pension begins.
--	---	--

*Note: The spouse allowance is reduced by the amount of the spouse's own employer provided benefits other than social security.*

Organizations that are or will be providing spouse's pensions(s)	Monthly Amount	Date Eligible

Did spouse receive pension(s) in lump sum distribution? <i>(Y/N)</i>	Date Received	Amount Received
--	---------------	-----------------

**DEPENDENT CHILD INFORMATION** (Required only if applying for health care assistance, unmarried students below age 19.)

Name	SS#	Date of Birth	Age	School Attending

Remarks	Signature of Applicant
---------	------------------------

Recommending action of Employing Organization:

Name of Organization	Signature of Officer Who Processed Application
Date of Action	Benefits Effective Date (should begin on 1 <sup>st</sup> of Month):

Person to communicate with if Retirement Plan Office has questions regarding applications.	Phone #
--	---------

**Recommendation of Local Conference** (For employees of local conference institutions)

Name of Local Conference	Date
Remarks	Signature of Officer
	Type Name:

**Recommendation of Union Conference** (For employees of local conferences and union institutions)

Name of Union Conference	Date
Remarks	Signature of Officer
	Type Name:

## JOINT & SURVIVOR ANNUITY WAIVER

**Participant's Name:** \_\_\_\_\_

**Spouse's Name:** 0 \_\_\_\_\_

1. We, the undersigned, understand that in signing this waiver, we are permanently forfeiting eligibility for the benefits listed in Number 2 below.
2. We, the undersigned, understand that the Joint & Survivor Annuity may provide the following benefits to the spouse of a participant of the Seventh-day Adventist Retirement Plan:
  - a. Health care expense assistance, which includes Medicare Part B premium reimbursement, and/or APS\* as long as the spouse lives.
  - b. Fifty percent of the participant's retirement benefits (excluding the spouse allowance) if the participant predeceases the spouse.
  - c. Funeral allowance at the death of the spouse based on church service only, except for participants eligible to retire before 01/01/1992.

***WARNING!* IF YOU HAVE ANY QUESTIONS REGARDING THIS FORM  
PLEASE ASK FOR CLARIFICATION BEFORE SIGNING!  
THIS IS A PERMANENT ELECTION THAT CANNOT BE REVERSED!**

**Participant** \_\_\_\_\_  
(Signature) (Date)

**Spouse** \_\_\_\_\_  
(Signature) (Date)

**Witness** \_\_\_\_\_  
Officer of Employing Organization or Notary Public - Signature (Date)

\* APS = Accrued Pension Supplement - see benefits worksheet.

Note: In accordance with policy (NAD Retirement Plan Z 20 40 and Hospital Retirement Plan Section 4.2), this written election must be filed at least 30 days prior to the retirement benefit starting date.

## RETIREMENT ALLOWANCE AUTHORIZATION

**We recommend that the North American Division Retirement Office pay the retirement allowance indicated below, and authorize the charge for an equal amount as a Retirement Plan Contribution.**

Employee Name and Address	0	SS#	0
	0	Retire Date	0
	0	Retire ID#	

Retirement Allowance is based on 0.00 pre-2000 years of service credit.

***Post-1999 RA is to be paid directly by employing organization.***

Full time monthly/hourly rate of remuneration on date eligible for benefits:

Amount of retirement allowance:	\$0.00	<i>(See next page for tax deferral option.)</i>
<i>(Formula: Current F/T Remuneration x 12.5% x pre-2000 YSC)</i>		

**Note: Calculation of the Retirement Allowance is subject to change following review of the service record by the Retirement Office.**

Last Employing Organization:  0	Authorizing Signature:   Date:
---------------------------------------	---

If the employee was called from another participating employer after his/her 60<sup>th</sup> birthday and the contribution should be billed proportionately, in accordance with NAD Z 40 10 (8), please identify the organization(s) below to share in the contribution cost:

*Note: Adventist Health Systems employers apply the sharing provision of NAD Z 40 10 (8) only when an employee transfers from a church employer to a hospital employer.*

**NOTE: Withholding tax of 20% will be deducted from the portion not paid in a direct rollover.**

**SEE NEXT PAGE**

**RETIREMENT ALLOWANCE  
ELECTION OF METHOD OF PAYMENT UNDER  
THE SEVENTH-DAY ADVENTIST RETIREMENT PLANS**

I hereby elect the following method(s) of payment for my distribution(s) from the Seventh-day Adventist Retirement Plan – a qualified church defined benefit plan as described by the IRS to be a 401(a) plan:

- ① ( ) DIRECT ROLLOVER of (select one):**  
 ( ) *ALL* of my Plan distribution  
 ( ) \$\_\_\_\_\_ of my Plan distribution (*\$500 or more*), the balance to be paid directly to me

Check (✓) Type of Plan:      \_\_\_ TSA    \_\_\_ IRA    \_\_\_ OTHER \_\_\_\_\_  
(Indicate Type of Plan)  
 \_\_\_ Adventist Retirement Plan (*VALIC - SDA403B - Rollover Form Required*)

Name of Plan:

Account Number:

Name and Address of  
Trustee or Custodian:

**REQUIRED FOR ALL ROLLOVERS: ONE OF THE FOLLOWING MUST BE PROVIDED WITH THE RA FORM (*check appropriate box*):**

- Name of Contact Person *or* Department where check is to be sent: \_\_\_\_\_  
 Telephone Number of Contact Person or Department: \_\_\_\_\_  
 A form from the TSA, IRA or Other Plan where Retirement Allowance is to be sent that includes account information for that institution (form to be mailed with R.A. check).

I represent that the above-named eligible retirement plan is an individual retirement account or individual retirement annuity established in my name, or a qualified defined contribution retirement plan or annuity plan which accepts direct rollovers.

- ② ( ) PAYMENT TO ME of (select one):**  
 ( ) *ALL* of my Plan distribution  
 ( ) \$\_\_\_\_\_ of my Plan distribution, the balance (*\$500 or more*) to be rolled over to the above account

I acknowledge that all amounts paid to me from the Plan, and *NOT* paid in a direct rollover, are subject to MANDATORY 20% WITHHOLDING for Federal Income Tax.

Name:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

NOTE: If you elect a direct rollover, this entire area MUST be completed. Your direct rollover check will be issued with the information YOU provide here.

**NOTE:** Above signature is for ① AND ② above – the Lump Sum will be paid according to the (✓).

## SOCIAL SECURITY ELECTION FORM (Alternate)

0

I understand I will not be eligible for Medicare based on my work as a minister. I have been informed that upon retirement my denominational health care assistance will be calculated as if I did have Medicare coverage normally provided for those in the Social Security program meaning that the denominational health care assistance from the denominational retirement plan will cover only expenses that would not normally be covered by Medicare.

Signatures Witnessed By:

\_\_\_\_\_  
*Signature of Minister*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Witness*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Spouse*

\_\_\_\_\_  
*Date*

*NOTE: This form is to be completed by all ministers not having one of the standard Social Security Election Form (Ministers) attached to their service records.*

---

### MEMO FROM EMPLOYING ORGANIZATION:

The minister referred to above has been informed regarding U.S. Social Security for ministers.

\_\_\_\_\_  
*Signature of Administrative Officer of Employing Organization*

\_\_\_\_\_  
*Date*

## Authorization Agreement for Direct Deposit

**Company Name:** General Conference of Seventh-day Adventists

**Company ID Number:** 52 - 2000393

### Part I. — Retiree Information

**Name**

**Social Security #** 0

**Signature**

**Date:**

### Part II. — Bank Information *(Must be able to receive funds from the Federal Reserve System)*

**Bank Routing Number (9 Digits)**

**Bank Account Number**

**Type of Account (Check One)**

**Checking**

**Savings**

**Name & Mailing Address of Bank**

**Bank Phone Number**

**Return Form To:** General Conference of Seventh-day Adventists  
ATTN: Retirement Payroll Office  
12501 Old Columbia Pike  
Silver Spring MD 20904

***Fax: (301) 680-6190***

# SPOUSE ALLOWANCE DISCLOSURE FORM

<b>Participant's Name</b>	
<b>Spouse's Name</b>	<b>0</b>

We, the undersigned, understand that the participant's total monthly retirement benefits will include a separate Spouse Allowance component. That portion of the benefits will continue to the participant as long as the marital status of the undersigned remains the same as it is on the benefit effective date and the spouse does not begin receiving employer-provided benefits of his/her own.

We acknowledge that it is our responsibility to provide written notification to the retirement office should our marital status change--due to death or divorce--or at such time as the non-participant spouse receives employer-provided benefits of his/her own.

In the event of such personal changes, we understand that the Spouse Allowance component of the total monthly benefits will be adjusted according to policy and that any overpayments of the Spouse Allowance will be returned to the Retirement Fund either through direct payment or payroll deduction.

\_\_\_\_\_  
Signature of *Participant*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of *Spouse*

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of *Witness* (Officer of Employing Organization – or Notary Public)

\_\_\_\_\_  
Date

**NOTE: If you have any questions regarding this form, please ask for clarification.**

# HEALTHCARE DISCLOSURE FORM

***Post-77 ITR Retirees Receiving NAD Retirement Benefits PLUS  
Being Paid Retirement Benefits from NAD on Behalf of Home Division***

**Participant's Name** \_\_\_\_\_

**Spouse's Name** \_\_\_\_\_

The NAD Retirement Office is contacting your home division to explain the Supplemental Healthcare, Adventist Retirement Plan (SHARP) system and invite them to participate in sharing in the cost of the monthly Earned Credit for continued SHARP participation. If your division is unwilling to cover their portion of the Earned Credit, then ALL of your healthcare coverage will be based on out-patient and in-patient percentages which are based on your combined overseas and NAD service credit. This may require that paid medical receipts be mailed to the Adventist Risk Management, Inc. office for reimbursement.

In signing below I, **<Retiree Name>**, hereby acknowledge that if and when my overseas benefits are paid to me by the North American Division Retirement Office on behalf of my home division, I may no longer be eligible for healthcare coverage under the Supplemental Healthcare, Adventist Retirement Plan (SHARP). I also understand that at the time my home division benefits begin being paid from the NAD Retirement Office, my TOTAL healthcare coverage may be based on out-patient and in-patient percentages based on my combined overseas and NAD service credit, with the overseas portion billed to my home division. Paid receipts may need to be mailed to the Adventist Risk Management, Inc. office for reimbursement.

\_\_\_\_\_  
Signature of **Participant**

\_\_\_\_\_  
Date \*

\_\_\_\_\_  
Signature of **Spouse**

\_\_\_\_\_  
Date \*

\_\_\_\_\_  
Signature of **Witness** (Officer of Last Denominational Employer – or Notary Public)

\_\_\_\_\_  
Date \*

**\* Retiree/Spouse/Witness Signatures must be dated the same.**

**EARLY RETIREMENT DISCLOSURE**  
*(Retirees with less than 40 YSC)*

I, \_\_\_\_\_, have applied for early retirement benefits. I understand that applying for benefits before my normal retirement age results in a ***permanent*** 0.5% reduction for each month I am younger than my normal retirement age, or for each month qualifying service credit is less than 40 years, whichever yields the greater monthly benefit.

I also understand that if I qualify for and elect SHARP healthcare coverage but am not yet Medicare age, SHARP provides healthcare assistance for me and/or my eligible spouse/dependent(s) ***at personal expense*** until I reach Medicare age eligibility.

**Early Retirement Effective Date** \_\_\_\_\_  
*(MM/DD/YYYY)*

**Retiree's Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Witness Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

*(Must be last denominational employer OR Notary Public)*

---

⇒ **PLEASE KEEP A COPY OF THIS DOCUMENT FOR YOUR FILES** ⇐

---