



CHRISTIAN SCHOOLS
INTERNATIONAL

**CHRISTIAN SCHOOL PENSION
PLAN AND TRUST FUND**

3350 East Paris Ave SE
Grand Rapids, MI 49512-3054

EMPLOYEE APPLICATION FORM

Employee's Name _____ Single _____ Married _____ Maiden Name _____
Address _____ City _____ State _____ Zip _____
Date of Birth _____ Sex _____ M _____ F Soc. Sec. No _____
Home Phone _____ School Name _____
Email address (required to allow you access to your benefit information) _____
Position _____ Administrator _____ Teacher _____ Clerical _____ Custodian _____ Other _____

I have previously participated in this Plan. _____ Yes _____ No

NOTE: If yes, check with the Pension office for information on possible reinstatement of canceled service credits.

I have previously participated in the CSI Canada Pension Plan. _____ Yes _____ No

I have _____ have not _____ at any time been incapacitated because of illness for a period longer than four weeks. (If so, give nature of illness and length of disability:) _____

To the best of my knowledge I do _____ do not _____ have any physical defects now, which may eventually disqualify me for efficient service. (If so, please state:) _____

Beneficiary's name _____ Soc.Sec.No. _____ Relationship _____

Beneficiary's address _____ City _____ State _____ Zip _____

(If benefits are to be paid to a minor, the Plan Administrator, at its discretion, may make such benefits payable to a legal guardian or if none, to a parent with whom the minor resides.)

Spouse's name _____ Date of marriage _____

Spouse's date of birth _____

I hereby certify that I am eligible to participate and that to the best of my knowledge the information given above is correct and true to fact. *(For information on eligibility, see reverse side)*

Signed _____ Date _____

SPOUSE CONSENT

If you are married and wish to designate someone other than your spouse as your beneficiary, your spouse must give written notarized consent to the beneficiary of your choice.

As the spouse of the above-named employee, I consent to the beneficiary designation listed above. I understand that under this designation no death benefits will be paid to me from this Plan.

Spouse Signature _____ Date _____

Signed before me this _____ day of _____, 20 _____

Commission Expiration Date _____

Signature of Notary Public

(STAMP SEAL HERE)

(Please have your Employer complete the reverse side)

ELIGIBILITY:

- a. All Employees employed on a half-time or more basis, must participate in the Plan as of the date of their employment. Effective September 1, 2009 a change in the Plan gives a school the choice of electing the “once in always in” option and continuing to enroll all employees employed on a half time or more basis. They will also enroll all employees working less than half time *who have prior service credits regardless of the number of hours they work*. A school **not** electing “once in always in” will only enroll those employees who are employed on a half time or more basis. This choice is made with enrollment of each new Plan Year and carried by the school for the whole Plan Year.

- b. Employees scheduled to work less than half-time must be enrolled:
 - if they complete 1,000 hours in a Plan Year. They must be retroactively enrolled to the first day of that Plan Year or to their date of employment if later.
 - if they complete 1,000 hours in the 12 month period beginning with their date of employment. They must be enrolled to the first day of the Plan Year that begins in that 12 month period.

- c. Employees receiving retirement benefits from the Plan must participate if they work 1,000 hours in a Plan Year.

- d. All leased Employees who provide services on a full-time basis for at least one year must participate. (Refer to Section 1.24 of the Plan booklet for specifics.)

- e. Ordained ministers eligible to participate in a church sponsored retirement plan may choose to be excluded.

- f. Shared time employees who work half-time or more may participate. If so elected, all such employees at the school must participate.

TO BE COMPLETED BY EMPLOYER:	School No: _____
Employee’s Name: _____	Employee’s SSN: _____
Employee’s Date of Employment: _____	Salary for Plan Year: _____
Employee’s Plan Participation Date: _____	
If Date of Employment is different from Participation Date, please explain why. _____	
