IOWA CONFERENCE
The United Methodist Church

Iowa Conference Board of Pension
Application for Assistance

Assistance request for: ☐Individual or ☐ Local Church Date:

Name of Individual or Local Church:

Address: City: Zip:

Select the type of assistance requested of the Iowa Conference Board of Pension:

Individual Medical Assistance -

☐Family Health Insurance Premiums Amount: # of Months: Total:

☐Medical Expenses Amount: # of Months: Total:

☐Other Amount: # of Months: Total:

Direct Bill Assistance for Local Churches –

☐Church Health Share Amount: # of Months: Total:

☐Church Pension Share Amount: # of Months: Total:

☐Other Amount: # of Months: Total:

Briefly describe the situation that has led to the request for assistance. Please do not include any specific personal health information.

How will this assistance make a difference to the individual or local church?

Action of the CBOP Assistance Committee (Requests above $2,500 must be approved by the full CBOP or Executive Committee of the CBOP):

☐Approved as Presented ☐Denied ☐Modified -

Signatures:

_____ _____
District Superintendent Date

_____ _____
Conference Benefit Officer Date

_____ _____
Treasurer Date