THE EPISCOPAL CHURCH MEDICAL TRUST
445 Fifth Avenue
New York, NY 10016
Active Member Services: (800) 480-9967
Fax: (212) 592-9499
www.cpg.org

# Employee Group Medical and Dental Enrollment Form

## 1 Information About the Employee

❑ New Employee (See Enrollment Guidelines on back)
❑ Late Enrollment (Include Health Statement)

Date Hired ___/___/___ Mo / Day / Yr

Coverage Effective ___/___/___ Mo / Day / Yr

_____ Years of credited service (retirees only)

Title First Name M.I. Last Name
**(The Rev., Mr., Mrs., Ms., etc.)**

Birth Date ___/___/___ Mo / Day / Yr

Soc. Sec. No. ___-___-___

**Residence**

Street

City State Zip

Home Phone E-mail

❑ Male ❑ Female
❑ Married ❑ Single
❑ Clergy ❑ Lay
❑ Seminarian

**Mailing Address (if different)**

Street

City State Zip

## 2 Billing Information for Medical and Dental Plans

Name of Organization

Phone E-mail List Bill ID

Street

City State Zip

**Billing Instructions:**

Send bill to the attention of _____

## 3 Active Medical Coverage

❑ Medical coverage declined

Name of Plan Carrier Type of Plan (HMO, PPO, etc.)

Tier: ❑ Single ❑ Employee + 1 (spouse)
❑ Employee + child ❑ Employee + children ❑ Family

## 4 Dental Coverage

❑ Dental coverage declined

Name of Plan Carrier Type of Plan (Preventative, $25, $50, etc.)

Tier: ❑ Single ❑ Employee + 1 (spouse)
❑ Employee + child ❑ Employee + children ❑ Family

## 5 Retiree Medical Coverage

Name of Plan Choice for Retiree Retirement Date (Mo/Day/Yr)

Name of Plan Choice for Spouse Date of Marriage (Mo/Day/Yr)*

***Include copies of legal marriage documents**

## 6 Information About Your Dependents

List dependents and check coverage desired. Dependents 19 and over (full-time students,etc.) may be eligible – check Administrative Guidelines for your diocese or organization. If your group offers domestic partnership coverage, attach supporting documentation with this form. For more space, attach an additional Enrollment Form.

| Coverage | Full Name | Relationship | Soc. Sec. No. | Birth Date (M/D/Y) | Gender |
|---|---|---|---|---|---|
| ❑ Medical<br>❑ Dental | | | - - | / / | ❑ M<br>❑ F |
| ❑ Medical<br>❑ Dental | | | - - | / / | ❑ M<br>❑ F |
| ❑ Medical<br>❑ Dental | | | - - | / / | ❑ M<br>❑ F |

## 7 Signatures – Employee, Employer, and Sponsoring Diocese or Organization

The employee, employer, and an officer of the sponsoring diocese or organization must sign this form. By signing, the Employer certifies the employee is eligible for all coverages applied for, and, to the best of the employer's knowledge, all information provided is correct.

Employee's Signature* Date

Employer's Signature Date

Name of Sponsoring Diocese or Organization

Officer's Signature Date

Street City State Zip Phone E-mail

***Include Power of Attorney documentation if applicable.**

## 8 Enrollment Guidelines

- For Group Medical Benefits, if the Health Insurance Portability and Accountability Act of 1996 (HIPAA) applies, you must include evidence of your prior health coverage with this form.
- New employees must enroll and sign this form within 30 days of hire or eligibility date for Group Medical/Dental Insurance.
- If enrolling in a Managed Care Plan, attach Managed Care application. Managed Care plans do not accept late enrollments.
- All late enrollments subject to approval.