EPISCOPAL CHURCH MEDICAL TRUST
19 East 34th Street
New York, NY 10016
Client Engagement: (800) 480-9967
Fax: (877) 432-9274
www.cpg.org

Employee Group Medical and Dental Enrollment Form

1 Information About the Employee

☐ New Employee

☐ Other _____

Date Hired _____ Mo/Day/Yr

Coverage Effective _____ Mo/Day/Yr

_____
Title First Name M.I. Last Name

Birth Date _____ Mo/Day/Yr

Soc. Sec. No. _____

Residence

_____
Street

_____
City State Zip

_____
Home Phone Email

☐ Male ☐ Married ☐ Clergy
☐ Female ☐ Single ☐ Lay

Mailing Address (if different)

_____
Street

_____
City State Zip

Spouse

_____
First Name M.I. Last Name

Birthdate _____ Soc Sec No _____

2 Billing Information for Medical and Dental Plans

_____
Name of Church or Organization

_____
Phone Email

_____
Street

_____
City State Zip

Billing Instructions:

Send bill to the attention of _____

3

Active Medical Coverage

Anthem BCBS
Name of Plan Carrier

☐ **PPO 80**
☐ **CDHP 15**
☐ **CDHP 20**
Plan Choice (Check one)

Tier:
☐ Single
☐ Employee + 1 (spouse)
☐ Employee + child
☐ Family

☐ Medical coverage declined

4

Active Dental Coverage

Delta Dental
Name of Dental Plan Carrier

☐ **Comprehensive**
☐ **Premium** *(costs additional)*
Plan Choice (Check one)

Tier:
☐ Single
☐ Employee + 1 (spouse)
☐ Employee + child
☐ Family

☐ Dental coverage declined

5 Information About Your Dependents

Coverage	Full Name	Relationship	Soc. Sec. No.	Birth Date (M/D/Y)	Gender
☐ Medical ☐ Dental					☐ Male ☐ Female
☐ Medical ☐ Dental					☐ Male ☐ Female
☐ Medical ☐ Dental					☐ Male ☐ Female

Attach an additional page for more than 3 dependents

6 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
Senior Warden or Treasurer

Diocese of Iowa
Name of Sponsoring Diocese or Organization

Diocesan Officer's Signature Date

225 37th St.,	**Des Moines**	**IA**	**50312**	**515-277-6165**
Street	City	State	Zip	Phone

*Include Power of Attorney documentation if applicable.

financial@iowaepiscopal.org
Email

7 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.

RETURN THIS COMPLETED FORM TO:
Anne Wagner at financial@iowaepiscopalorg
or mail to 225 37th St., Des Moines, IA 50312