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The Episcopal Church Medical Trust

RETURN COMPLETED FORM TO:
Episcopal Diocese of Iowa, 225 37th St., Des Moines, IA 50312

**Employee Group Medical
and Dental Change Form**

1 Information About the Employee

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

Soc. Sec. No. _____

Date Hired _____

_____ Years of credited service (retirees only)

2 Reasons for and Date of Change

- Terminated
- Deceased member
- Deceased dependent
- Change of Address
- Early Retirement
- Age 65+ retirement
- Change in billing information
- Change in eligibility of dependent
- Transferred from another parish in same diocese
- Marriage*
- Divorce*
- Other significant life change

Change Effective _____
Mo/Day/Yr

*Include copies of legal marriage documents

3 Employee's New Address (if applicable)

Residence

Mailing Address (if different)

Street _____

Street _____

City State Zip

City State Zip

Home Phone E-mail

4 Changes in Billing Information (if applicable)

Name of Episcopal Organization _____

Phone E-mail List Bill ID

Street _____

City State Zip

- Bill to Episcopal Organization
- Bill directly to Member (Retirees only)
- Pension deduction (Retirees only)*

If billing for retiree and spouse is different, please provide instructions for spouse on a separate sheet.

*If checked, please attach Pension Deduction Form.

5 Change in Active Medical Coverage (if applicable)

- Terminate Medical Coverage
- Add or change Medical Plan

Change Medical coverage from
(Tier) _____ to (Tier) _____

From _____
Name of Current Plan Type of Plan (HMO, PPO, etc.)

To _____
Name of New Plan Type of Plan

(see section 10 for list of tiers; complete section 8 if appropriate)

6 Change in Active Dental Coverage (if applicable)

Terminate Dental Coverage Add or change Dental Plan

Change Dental coverage from _____ From _____
 (Tier) _____ to (Tier) _____ Name of Current Plan Type of Plan (Basic, Preventive)

To _____
 Name of New Plan Type of Plan

(see section 10 for list of tiers; complete section 8 if appropriate)

7 Change in Retiree Medical Coverage (if applicable)

Terminate Retiree Medical Coverage Add or change Retiree Medical Plan

Change Retiree Medical coverage from _____ From _____
 (Tier) _____ to (Tier) _____ Name of Current Plan

To _____
 Name of New Plan

(see section 10 for list of tiers; complete section 8 if appropriate)
 If Active Medical Plan chose, please complete Section 5.

8 Change Dependents (if applicable)*

| Change | Full Name | Relationship | Soc. Sec. No. | Birth Date (M/D/Y) | Gender |
|---------------------------------|-----------|--------------|---------------|--------------------|----------------------------|
| <input type="checkbox"/> Add | _____ | _____ | _____ | ____/____/____ | <input type="checkbox"/> M |
| <input type="checkbox"/> Cancel | _____ | _____ | - - | / / | <input type="checkbox"/> F |
| <input type="checkbox"/> Add | _____ | _____ | _____ | ____/____/____ | <input type="checkbox"/> M |
| <input type="checkbox"/> Cancel | _____ | _____ | - - | / / | <input type="checkbox"/> F |
| <input type="checkbox"/> Add | _____ | _____ | _____ | ____/____/____ | <input type="checkbox"/> M |
| <input type="checkbox"/> Cancel | _____ | _____ | - - | / / | <input type="checkbox"/> F |

If you need more space, attach an additional Enrollment Form.
 *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 documentaion with this form.

9 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 _____

Episcopal Diocese of Iowa _____
 Name of Sponsoring Diocese or Organization Officer’s Signature _____ Date _____

Street _____ City _____ State _____ Zip _____ Phone _____ E-mail _____

*Include Power of Attorney documentation if applicable.

10 Explanation of Tiers of Coverage

Tiers for Active Medical and Dental Coverage:*

Single, employee + 1 (spouse), employee + child, Employee + children, Family

*All tiers may not be available in your diocese or organization. Contact The Medical Trust with questions.

Tiers for Retiree Medical Coverage:*

Single, employee + 1, One Medicare/One Non-Medicare