CHURCH PENSION GROUP

445 Fifth Avenue
New York, NY 10016
Active Member Services: 800.480.9967
Retiree Member Services: 866.273.4545
Fax (both): 212.592.9499
www.cpg.org

The Episcopal Church Medical Trust
Church Life Insurance Corporation

Group Medical, Dental and Disability Insurance Enrollment Form

1 Information About the Employee

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

_____ Years of credited service (retirees only)

Date Hired __/__/__ Mo / Day / Yr

Coverage Effective __/__/__ Mo / Day / Yr

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

Mailing Address (if different)

Street

City State Zip

❏ Active
❏ Retired

❏ Male
❏ Female

❏ Married
❏ Single

❏ Clergy
❏ Lay

❏ Seminarian
❏ Surviving Spouse

2 Billing Information for Medical and Dental Plans

Name of Episcopal Organization

Phone E-mail List Bill ID

Street

City State Zip

Billing Instructions:

❏ 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.**

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.**

If Active Medical Plan chosen, please complete Section 3.

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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 ❑ Dental			- -	/ /	❑ M ❑ F
❑ Medical ❑ Dental			- -	/ /	❑ M ❑ F
❑ Medical ❑ Dental			- -	/ /	❑ M ❑ F

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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.**

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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, and within 60 days for Group Disability Insurance.