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

Mailing Address (if different)

_____

Street

_____

City State Zip

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

2 Billing Information for Medical and Dental Plans

_____

Name of Organization

_____ _____

Phone Email List Bill ID

_____

Street

_____

City State Zip

Billing Instructions:

Send bill to the attention of _____

3 Active Medical Coverage

_____

Name of Plan Carrier Plan Name (EPO 80, POS II, etc)

☐ Medical coverage declined

Tier:

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

4 Active Dental Coverage

_____

Name of Dental Plan

☐ Dental coverage declined

Tier:

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

❺ 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

❻ 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 Email

*Include Power of Attorney documentation if applicable.

❼ 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.