



**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

Birth
Date _____
Mo/Day/Yr

Coverage
Effective _____
Mo/Day/Yr

Soc.
Sec. No. _____

Title First Name M.I. Last Name

Residence

Mailing Address (if different)

Street

Street

City State Zip

City State Zip

Home Phone Email

- 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

5 Information About Your Dependents

Coverage	Full Name	Relationship	Soc. Sec. No.	Birth Date (M/D/Y)	Gender
<input type="checkbox"/> Medical					<input type="checkbox"/> Male
<input type="checkbox"/> Dental					<input type="checkbox"/> Female
<input type="checkbox"/> Medical					<input type="checkbox"/> Male
<input type="checkbox"/> Dental					<input type="checkbox"/> Female
<input type="checkbox"/> Medical					<input type="checkbox"/> Male
<input type="checkbox"/> Dental					<input type="checkbox"/> Female

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	
_____ Name of Sponsoring Diocese or Organization				_____ Officer’s Signature		_____ Date	
_____ Street		_____ City		_____ State Zip		_____ Phone Email	

*Include Power of Attorney documentation if applicable.

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.