CHURCH PENSION GROUP

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New York, NY 10016
Active Member Services: 800.480.9967
Fax (both): 212.592.9499
www.cpg.org

The Episcopal Church Medical Trust

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*

***Include copies of legal marriage documents**

☐ Other significant life change

_____

Change Effective _____ Mo/Day/Yr

3 Employee's New Addresss (if applicable)

Residence

Street

AK

City State Zip

Home Phone E-mail

Mailing Address (if different)

Street

AK

City State Zip

4 Changes in Billing Information (if applicable)

Name of Episcopal Organization

Phone E-mail List Bill ID

Street

AK

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

◯ Change Medical coverage from

(Tier) _____ to (Tier) _____

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

◯ Add or change Medical Plan

From _____

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

To _____

Name of New Plan Type of Plan

6 Change in Active Dental Coverage (if applicable)

○ Terminate Dental Coverage

○ Change Dental coverage from

(Tier) _____ to (Tier) _____

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

○ Add or change Dental Plan

From _____
Name of Current Plan Type of Plan (Basic, Preventive)

To _____
Name of New Plan Type of Plan

7 Change in Retiree Medical Coverage (if applicable)

○ Terminate Retiree Medical Coverage

○ Change Retiree Medical coverage from

(Tier) _____ to (Tier) _____

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

If Active Medical Plan chose, please complete Section 5.

○ Add or change Retiree Medical Plan

From _____
Name of Current Plan

To _____
Name of New Plan

8 Change Dependents (if applicable)*

Change	Full Name	Relationship	Soc. Sec. No.	Birth Date (M/D/Y)	Gender
○ Add ○ Cancel			- -	/ /	○ M ○ F
○ Add ○ Cancel			- -	/ /	○ M ○ F
○ Add ○ Cancel			- -	/ /	○ M ○ 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

Name of Sponsoring Diocese or Organization

Officer's Signature Date

Street City State Zip Phone E-mail

AK

***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