THE EPISCOPAL CHURCH MEDICAL TRUST

2019 GROUP ENROLLMENT FORM

Listed below are the health plan choices offered by your group and the associated monthly rates for each. If you wish to select coverage, please complete the appropriate spaces below and check the box next to your 2019 Health Plan Choices and indicate the Tier (Single,etc.).

Member Information

Name

Address

City, State, Zip

Date of Birth *Social Security No.*

Hire Date M ☐ F ☐ *Gender*

Diocese of Dallas

0166 *Group #*

Medical Billing Unit

Employer's Name

Employer's Address

Dependent Information

You may obtain coverage for your eligible children who are age 30 or younger. If your group offers domestic partnership coverage, attach supporting documentation with this form. If you wish to enroll one or more dependents, please attach an additional sheet which includes the following information for each: Name, Social Security Number, Gender (M/F), Date of Birth, and Relationship to Employee (Spouse, Child).

2019 Health Plan Choices

MEDICAL

Option Code	2019 Election (check one) Plan Name	Single	Emp+1	Emp+chd	Family
MEAP	☐ EAP	$5	$5	$5	$5
MHDE	☐ Anthem BCBS CDHP-20/HSA	$671	$1,342	$1,208	$2,013
MPP2	☐ Anthem BCBS BlueCard PPO 90	$889	$1,778	$1,600	$2,667
MPP3	☐ Anthem BCBS BlueCard PPO 80	$807	$1,614	$1,453	$2,421
MPP4	☐ Anthem BCBS BlueCard PPO 70	$735	$1,470	$1,323	$2,205
	☐ I decline medical coverage				

MEDICAL (check one)

☐ **Single**
☐ **Emp+1**
☐ **Emp+chd**
☐ **Family**

DENTAL

Option Code	2019 Election (check one) Plan Name	Single	Emp+1	Emp+chd	Family
DD25	☐ Dent&Ortho-25/75	$76	$152	$137	$228
DD50	☐ Basic Dent-50/150	$55	$110	$99	$165
DDPV	☐ Preventive Dental	$43	$86	$77	$129
	☐ I decline dental coverage				

DENTAL (check one)

☐ **Single**
☐ **Emp+1**
☐ **Emp+chd**
☐ **Family**

When you have made your decision, sign and return this form to your administrator as indicated below.

Employee's Signature *Date*

RETURN THIS FORM TO:

Susan Lee Mills
Diocese of Dallas
1630 N. Garrett Avenue
Dallas, TX 75206-7702
smills@edod.org

TO BE COMPLETED BY THE GROUP ADMINISTRATOR

I hereby certify that this applicant is eligible for coverage and, to the best of my knowledge, all information provided above is correct.

Administrator's Signature