



2025 Employee Group Medical and Dental Enrollment Form

1. Information About the Employee

- New Employee *(Employer must complete and return New Hire Form to the Office of the Bishop with this form)*
 Annual Enrollment

Residence:

Street

City

State

Zip

Title First Name M.I. Last Name
(The Rev., Mr., Mrs., Ms. Etc.)

Home Phone

E-mail

- Male Married Clergy Seminarian
 Female Single Lay

Mailing Address *(If Different)*:

Date Hired

Birth Date

Street

Coverage Effective Date

Social Security Number

City

State

Zip

2. Billing Information for Medical and Dental Plans

Name of Congregation or Institution

Phone Number

City

Email

3. Active Medical Coverage

- | | |
|---|--|
| <input type="checkbox"/> Anthem BCBS BlueCard MSP PPO 70 | <input type="checkbox"/> Cigna OAP PPO 70 |
| <input type="checkbox"/> Anthem BCBS BlueCard MSP PPO 80 | <input type="checkbox"/> Cigna OAP PPO 80 |
| <input type="checkbox"/> Anthem BCBS BlueCard MSP PPO 90 | <input type="checkbox"/> Cigna OAP PPO 90 |
| <input type="checkbox"/> Anthem BCBS BlueCard MSP PPO 100 | <input type="checkbox"/> Cigna OAP PPO 100 |
| <input type="checkbox"/> Anthem BCBS BlueCard PPO 70 | <input type="checkbox"/> Cigna OAP CDHP-15/HSA |
| <input type="checkbox"/> Anthem BCBS BlueCard PPO 80 | <input type="checkbox"/> Kaiser CDHP – 20/HSA |
| <input type="checkbox"/> Anthem BCBS BlueCard PPO 90 | <input type="checkbox"/> Kaiser Permanente EPO 80 Plan (Kaiser Low) |
| <input type="checkbox"/> Anthem BCBS BlueCard PPO 100 | <input type="checkbox"/> Kaiser EPO High |
| <input type="checkbox"/> Anthem BCBS CDHP – 15/HSA | |
| <input type="checkbox"/> Cigna OAP MSP PPO 70 | <input type="checkbox"/> I Waive my right to medical coverage |
| <input type="checkbox"/> Cigna OAP MSP PPO 80 | <input type="checkbox"/> I would like to sign up for EAP (Employee Assistance Program) only coverage |
| <input type="checkbox"/> Cigna OAP MSP PPO 90 | |
| <input type="checkbox"/> Cigna OAP MSP PPO 100 | |

(This coverage is \$4 per family and is available for employers to purchase for employees who waive their right to medical coverage. It is included in all Medical Trust medical plans.)

4. Active Dental Coverage

- Delta Dental Basic
 Delta Dental Comprehensive
 Delta Dental Premium

I Waive my right to dental coverage

5. Information About Your Dependents (Child(ren), Spouse, Domestic Partner)

List dependents and check coverage desired.

Coverage	Full Name	Relationship	Social Security Number	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
<input type="checkbox"/> Medical					<input type="checkbox"/> Male
<input type="checkbox"/> Dental					<input type="checkbox"/> Female

6. Signatures – Employee & Employer

The employee, and employer 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

Name of Church or Organization

*Include Power of Attorney documentation if applicable

Employer's Signature Date

7. Enrollment Guidelines

- New employees must enroll and sign this form within **30** days of hire or eligibility date for Group Medical/Dental Insurance.
Fax this form to 916-442-6927, Attn: Benefits
OR mail it to: The Episcopal Diocese of Northern California
Attn: Benefits
2394 Fair Oaks Blvd.
Sacramento, CA 95825
- All late enrollments will be subject to review for approval.