THE EPISCOPAL CHURCH MEDICAL TRUST
445 Fifth Avenue
New York, NY 10016
Active Member Services: (800) 480-9967
Fax: (212) 592-9499
www.cpg.org

The Episcopal Diocese of Northern California
2394 Fair Oaks Blvd.
Sacramento, CA 95825

2026 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 ☐ Life Event _____

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

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

Date Hired Birth Date

Coverage Effective Date Social Security Number

Residence:

Street

City State Zip

Home Phone

E-mail

Mailing Address (*If Different*):

Street

City State Zip

2. Billing Information for Medical and Dental Plans

Name of Congregation or Institution Phone Number

City Email

3. Active Medical Coverage

☐ Anthem BCBS BlueCard MSP PPO 70
☐ Anthem BCBS BlueCard MSP PPO 80
☐ Anthem BCBS BlueCard MSP PPO 90
☐ Anthem BCBS BlueCard MSP PPO 100
☐ Anthem BCBS BlueCard PPO 70
☐ Anthem BCBS BlueCard PPO 80
☐ Anthem BCBS BlueCard PPO 90
☐ Anthem BCBS BlueCard PPO 100
☐ Anthem BCBS CDHP – 15/HSA
☐ Cigna OAP MSP PPO 70
☐ Cigna OAP MSP PPO 80
☐ Cigna OAP MSP PPO 90
☐ Cigna OAP MSP PPO 100

☐ Cigna OAP PPO 70
☐ Cigna OAP PPO 80
☐ Cigna OAP PPO 90
☐ Cigna OAP PPO 100
☐ Cigna OAP CDHP-15/HSA
☐ Kaiser CDHP – 20/HSA
☐ Kaiser Permanente EPO 80 Plan (Kaiser Low)
☐ Kaiser EPO High

☐ I Waive my right to medical coverage
☐ I would like to sign up for EAP (Employee Assistance Program) only coverage
(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

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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
☐Medical ☐Dental					☐Male ☐Female
☐Medical ☐Dental					☐Male ☐Female
☐Medical ☐Dental					☐Male ☐Female
☐Medical ☐Dental					☐Male ☐Female

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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

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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.