THE EPISCOPAL CHURCH MEDICAL TRUST **2018 GROUP ENROLLMENT FORM**

Listed below are the health plan choices offered by your group and the associated monthly rates for each, effective January 1, 2018. If you wish to select coverage, please complete the appropriate spaces below and check the box next to your 2018 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 Western Michigan

1065 *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).

2018 Health Plan Choices

MEDICAL

Option Code	2018 Election (check one) Plan Name	Single	Emp+1	Family
MHDE	☐ Anthem BCBS CDHP-20/HSA	$571	$1,028	$1,599
MHDG	☐ Anthem BCBS CDHP-15/HSA	$646	$1,163	$1,809
MPP2	☐ Anthem BCBS BlueCard PPO 90	$814	$1,465	$2,279
MPP3	☐ Anthem BCBS BlueCard PPO 80	$738	$1,328	$2,066
MPP4	☐ Anthem BCBS BlueCard PPO 70	$673	$1,211	$1,884
MS10	☐ Anthem BCBS BlueCard MSP PPO 90	$651	$1,172	$1,823
MS11	☐ Anthem BCBS BlueCard MSP PPO 80	$591	$1,064	$1,655
MS12	☐ Anthem BCBS BlueCard MSP PPO 70	$538	$968	$1,506
	☐ I decline medical coverage			

MEDICAL (check one)
☐ Single
☐ Emp+1
☐ Family

DENTAL

Option Code	2018 Election (check one) Plan Name	Single	Emp+1	Family
DD25	☐ Dent&Ortho-25/75	$76	$137	$213
DD50	☐ Basic Dent-50/150	$56	$101	$157
DDPV	☐ Preventive Dental	$36	$65	$101
	☐ I decline dental coverage			

DENTAL (check one)
☐ Single
☐ Emp+1
☐ Family

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

Employee's Signature *Date*

MAIL THIS FORM TO:

Tammy Mazure
Diocese of Western Michigan
535 S Burdick St Ste 1
Kalamazoo, MI 49007-5200

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 the information provided above is correct.

Administrator's Signature *Date*