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 2020 Health Plan Choices and indicate the Tier (Single, etc.)

Member Information

Diocese of Western Michigan

Name ____________________

Address ____________________

City,State Zip ____________________

Date of Birth ____________ Social Security No. ____________

Hire Date ____________ Gender M ☐ F ☐

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).

2020 Health Plan Choices

MEDICAL

2020 Election (check one)

Option Code	Plan Name	Single	Emp+1	Family
MEAP	☐ EAP	$4	$4	$4
MHDE	☐ Anthem BCBS CDHP-20/HSA	$657	$1,183	$1,840
MHDG	☐ Anthem BCBS CDHP-15/HSA	$743	$1,337	$2,080
MPP2	☐ Anthem BCBS BlueCard PPO 90	$923	$1,661	$2,584
MPP3	☐ Anthem BCBS BlueCard PPO 80	$837	$1,507	$2,344
MPP4	☐ Anthem BCBS BlueCard PPO 70	$763	$1,373	$2,136
MS10	☐ Anthem BCBS BlueCard MSP PPO 90	$738	$1,328	$2,066
MS11	☐ Anthem BCBS BlueCard MSP PPO 80	$670	$1,206	$1,876
MS12	☐ Anthem BCBS BlueCard MSP PPO 70	$610	$1,098	$1,708
	☐ I decline medical coverage			

MEDICAL (check one)

☐ **Single**
☐ **Emp+1**
☐ **Family**

DENTAL

2020 Election (check one)

Option Code	Plan Name	Single	Emp+1	Family
DD25	☐ Dent&Ortho-25/75	$80	$144	$224
DD50	☐ Basic Dent-50/150	$59	$106	$165
DDPV	☐ Preventive Dental	$44	$79	$123
	☐ 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
5347 Clyde Park Ave SW
Wyoming, MI 49509-9527

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* ____________