

Listed below are the health plan choices offered by your group and the associated monthly rates for each, effective January 1, 2021. If you wish to select coverage, please complete the appropriate spaces below and check the box next to your 2021 Health Plan Choices and indicate the Tier (Single, etc.)

Member Information

Name _____
 Address _____
 City, State Zip _____
 Date of Birth _____ Social Security No. _____
 Hire Date _____ Gender M F

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).

2021 Health Plan Choices

MEDICAL

Option Code	2021 Election (check one)		Single	Emp+1	Family	MEDICAL (check one)		
	Plan Name					Single	Emp+1	Family
MHDE	<input type="checkbox"/>	Anthem BCBS CDHP-20/HSA	\$703	\$1,265	\$1,968	<input type="checkbox"/>	Single	
MHDG	<input type="checkbox"/>	Anthem BCBS CDHP-15/HSA	\$795	\$1,431	\$2,226	<input type="checkbox"/>	Emp+1	
MPP2	<input type="checkbox"/>	Anthem BCBS BlueCard PPO 90	\$978	\$1,760	\$2,738	<input type="checkbox"/>	Family	
MPP3	<input type="checkbox"/>	Anthem BCBS BlueCard PPO 80	\$887	\$1,597	\$2,484			
MPP4	<input type="checkbox"/>	Anthem BCBS BlueCard PPO 70	\$809	\$1,456	\$2,265			
MS10	<input type="checkbox"/>	Anthem BCBS BlueCard MSP PPO 90	\$782	\$1,408	\$2,190			
MS11	<input type="checkbox"/>	Anthem BCBS BlueCard MSP PPO 80	\$710	\$1,278	\$1,988			
MS12	<input type="checkbox"/>	Anthem BCBS BlueCard MSP PPO 70	\$647	\$1,165	\$1,812			
	<input type="checkbox"/>	I decline medical coverage						

DENTAL

Option Code	2021 Election (check one)		Single	Emp+1	Family	DENTAL (check one)		
	Plan Name					Single	Emp+1	Family
DD25	<input type="checkbox"/>	Dent&Ortho-25/75	\$82	\$148	\$230	<input type="checkbox"/>	Single	
DD50	<input type="checkbox"/>	Basic Dent-50/150	\$60	\$108	\$168	<input type="checkbox"/>	Emp+1	
DDPV	<input type="checkbox"/>	Preventive Dental	\$46	\$83	\$129	<input type="checkbox"/>	Family	
	<input type="checkbox"/>	I decline dental coverage						

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