EPISCOPAL CHURCH MEDICAL TRUST

19 East 34th Street
New York, NY 10016
Client Engagement: (800) 480-9967
Fax: (877) 432-9274
www.cpg.org

Return to:
Matt Handi
290 Pratt St
Suite 52, 3rd Floor
Meriden, CT 06489

EPISCOPAL CHURCH IN CONNECTICUT
PARTICIPATING IN GOD'S MISSION

Employee Group Medical Form

1 Information About the Employee

☐ New Employee

☐ Other ________________

Date Hired ____________ Mo/Day/Yr

Coverage Effective ____________ Mo/Day/Yr

Birth Date ____________ Mo/Day/Yr

Soc. Sec. No. ____________

Title First Name M.I. Last Name

Residence

Street

City State Zip

Home Phone Email

Mailing Address (if different)

Street

City State Zip

☐ Male ☐ Female

☐ Married ☐ Single

☐ Clergy ☐ Lay

2 Billing Information for Medical and Dental Plans

Name of Organization

Phone Email List Bill ID

Street

City State Zip

Billing Instructions:

Send bill to the attention of ______________________________

3 Active Medical Coverage

Name of Plan Carrier Plan Name (EPO 80, POS II, etc)

☐ Medical coverage declined

Tier:

☐ Single
☐ Employee + 1 (spouse)
☐ Employee + child
☐ Family

15% Employee Contribution 2017 (FT)	CIGNA High Deductible HSA	Month	Anthem Blue Cross and Blue Shield 80/60	Month	CIGNAOpen Access Plus In-Network	Month	Dental	Month	Life	Month
Family	$3,326	$277	$4,153	$346	$5,015	$418	N/A	N/A	N/A	N/A
Two Person	$2,138	$178	$2,669	$222	$3,224	$269	N/A	N/A	N/A	N/A
Single	$1,188	$99	$1,483	$124	$1,791	$149	N/A	N/A	N/A	N/A

5 Information About Your Dependents

Coverage	Full Name	Relationship	Soc. Sec. No.	Birth Date (M/D/Y)	Gender
☐ Medical					☐ Male ☐ Female
☐ Medical					☐ Male ☐ Female
☐ Medical					☐ Male ☐ Female

6 Signatures – Employee, Employer, and Sponsoring Diocese or Organization

The employee, employer, and an officer of the sponsoring diocese or organization 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

Employer's Signature Date

Name of Sponsoring Diocese or Organization

Officer's Signature Date

Street City State Zip Phone Email

*Include Power of Attorney documentation if applicable.

7 Enrollment Guidelines

- For Group Medical Benefits, if the Health Insurance Portability and Accountability Act of 1996 (HIPAA) applies, you must include evidence of your prior health coverage with this form.
- New employees must enroll and sign this form within 30 days of hire or eligibility date for Group Medical/Dental insurance.

8

- Click button to submit form to ECCT Operations Manager.