THE EPISCOPAL CHURCH MEDICAL TRUST **2024 GROUP ENROLLMENT FORM**

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 2024 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 Tennessee

1230 *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).

2024 Health Plan Choices

MEDICAL

Option Code	2024 Election (check one) Plan Name	Single	Emp+1	Family
MEAP	☐ EAP	$4	$4	$4
MHDE	☐ Anthem BCBS CDHP-20/HSA	$820	$1,476	$2,296
MHDG	☐ Anthem BCBS CDHP-15/HSA	$969	$1,744	$2,713
MPP2	☐ Anthem BCBS BlueCard PPO 90	$1,145	$2,061	$3,206
MPP3	☐ Anthem BCBS BlueCard PPO 80	$1,038	$1,868	$2,906
MS10	☐ Anthem BCBS BlueCard MSP PPO 90	$915	$1,647	$2,562
MS11	☐ Anthem BCBS BlueCard MSP PPO 80	$830	$1,494	$2,324
	☐ I decline medical coverage			

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

DENTAL

Option Code	2024 Election (check one) Plan Name	Single	Emp+1	Family
DCOM	☐ Delta Dental Comprehensive	$55	$99	$154
DDBA	☐ Delta Dental Basic	$47	$85	$132
DPRE	☐ Delta Dental Premium	$73	$131	$204
	☐ 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:

Susan Abington
Diocese of Tennessee
3700 Woodmont Blvd Ste 107
Nashville, TN 37215-1800

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*