



**EPISCOPAL CHURCH  
MEDICAL TRUST**

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

www.cpg.org

**Employee Group Medical and  
Dental Enrollment Form**

**1**

**Information About the Employee**

New Employee

Other \_\_\_\_\_

Date  
Hired \_\_\_\_\_  
Mo/Day/Yr

Birth  
Date \_\_\_\_\_  
Mo/Day/Yr

Coverage  
Effective \_\_\_\_\_  
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  Married  Clergy
- Female  Single  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

**4**

**Active Dental Coverage**

\_\_\_\_\_  
Name of Dental Plan

Dental coverage declined

**Tier:**

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

**5** Information About Your Dependents

Coverage	Full Name	Relationship	Soc. Sec. No.	Birth Date (M/D/Y)	Gender
<input type="checkbox"/> Medical					<input type="checkbox"/> Male
<input type="checkbox"/> Dental					<input type="checkbox"/> Female
<input type="checkbox"/> Medical					<input type="checkbox"/> Male
<input type="checkbox"/> Dental					<input type="checkbox"/> Female
<input type="checkbox"/> Medical					<input type="checkbox"/> Male
<input type="checkbox"/> Dental					<input type="checkbox"/> 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.