THE EPISCOPAL CHURCH MEDICAL TRUST **2023 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 2023 Health Plan Choices and indicate the Tier (Single, etc.)

Member Information

_____ *Full Name (as it appears on your Social Security card)*

_____ *Street Address*

_____ *City, State, Zip Code*

_____ *Date of Birth* _____ *Social Security Number*

_____ *Hire Date* _____ *Gender*

Diocese of Dallas *Group Name*

0166 *Group #* _____ *Medical Billing Unit*

_____ *Employer's Name*

_____ *Employer's Address*

_____

Dependent Eligibility

You may obtain coverage for your spouse plus any eligible children (up to age 30 for ECMT benefits/up to age 26 for MetLife Dental). If you wish to enroll one or more dependents, please complete the information on page two.

2023 Health Plan Choices

MEDICAL

Option Code	2023 Election (check one)	Plan Name	Single	Emp + Spouse	Emp + Child	Emp + Family
MEAP	☐	EAP	$4	$4	$4	$4
MHDE	☐	Anthem BCBS CDHP-20/HSA	$814	$1,628	$1,465	$2,442
MPP2	☐	Anthem BCBS BlueCard PPO 90	$1,067	$2,134	$1,921	$3,201
MPP3	☐	Anthem BCBS BlueCard PPO 80	$969	$1,938	$1,744	$2,907
MPP4	☐	Anthem BCBS BlueCard PPO 70	$873	$1,746	$1,571	$2,619
	☐	I decline medical coverage				

Medical Tier (check one)

☐ **Single**
☐ **Emp + Spouse**
☐ **Emp + Child(ren)**
☐ **Emp + Family**

DENTAL

Option Code	2023 Election (check one)	Plan Name	Single	Emp + Spouse	Emp + Child	Emp + Family
ML	☐	MetLife Dental PPO	$50.83	$101.68	$105.77	$172.60
DD50	☐	Cigna Basic Dental PPO 50/150	$56.00	$112.00	$101.00	$168.00
DD25	☐	Cigna Dental/Orthodontia PPO 25/75	$77.00	$154.00	$139.00	$231.00
	☐	I decline dental coverage				

Dental Tier (check one)

☐ **Single**
☐ **Emp + Spouse**
☐ **Emp + Child(ren)**
☐ **Emp + Family**

When you have made your decision, sign and return this form to the Diocesan Administrator as indicated below.

☐ *I hereby certify that I am employed by the entity/entities named above for a total of at least 1000 regularly-scheduled hours annually and that I and any listed dependents are fully eligible to participate in the Denominational Health Plan (DHP) provided by ECMT.*

_____ *Employee's Signature* _____ *Date*

RETURN THIS FORM TO:

Susan Lee Mills (smills@edod.org)
214-826-8310 ext. 5
Diocese of Dallas
5100 Ross Avenue
Dallas, TX 75206-7709

TO BE COMPLETED BY THE GROUP ADMINISTRATOR

I hereby certify that, to the best of my knowledge, all of the information provided is correct.

_____ *Administrator's Signature* _____ *Date*

Dependent #1

Full Name (as it appears on Social Security card) *Date of Birth* *Social Security Number*

Gender *Relationship (Spouse or Child)* *Date of Relationship (marriage, adoption)*

Dependent #2

Full Name (as it appears on Social Security card) *Date of Birth* *Social Security Number*

Gender *Relationship (Spouse or Child)* *Date of Relationship (marriage, adoption)*

Dependent #3

Full Name (as it appears on Social Security card) *Date of Birth* *Social Security Number*

Gender *Relationship (Spouse or Child)* *Date of Relationship (marriage, adoption)*

Dependent #4

Full Name (as it appears on Social Security card) *Date of Birth* *Social Security Number*

Gender *Relationship (Spouse or Child)* *Date of Relationship (marriage, adoption)*

Dependent #5

Full Name (as it appears on Social Security card) *Date of Birth* *Social Security Number*

Gender *Relationship (Spouse or Child)* *Date of Relationship (marriage, adoption)*

Dependent #6

Full Name (as it appears on Social Security card) *Date of Birth* *Social Security Number*

Gender *Relationship (Spouse or Child)* *Date of Relationship (marriage, adoption)*