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, effective January 1, 2023.
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

Name

Address

City, State, ZIP

Date of Birth

Social Security Number

M ☐ F ☐
Gender

Hire Date

Diocese of Ohio

0695
Group #

Medical Billing Unit

Employer's Name

Employer's Address

Employer's City, State, ZIP

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).

2023 Health Plan Choices

MEDICAL

Option Code	2023 Election (check one) ↓	Plan Name	Single	Emp+sp	Emp+ch	Family
MHDE	☐	Anthem BCBS CDHP 15	$ 1,056	$ 2,112	$ 1,926	$ 3,043
MHDG	☐	Anthem BCBS CDHP 20	$ 1,071	$ 2,130	$ 1,962	$ 2,968
MPP2	☐	Anthem BCBS PPO 90	$ 1,162	$ 2,324	$ 2,092	$ 3,486
MS10	☐	Anthem PPO 90 MSP (Medicare Secondary Payer 65+)	$ 930	$ 1,860	$ 1,674	$ 2,790
MEAP	☐	Employee Assistance Program	$ 4	$ 4	$ 4	$ 4
	☐	I decline medical coverage.				

MEDICAL (check one)	
☐	Single
☐	Employee + spouse
☐	Employee + child(ren)
☐	Family

EAP is included with all medical plans.

You may decline medical and enroll in EAP

Note: The rates for the Anthem BCBS CDHP plans include the deductible to be funded in a health savings account (HSA).
Single: CDHP 15 = $125.00/month; CDHP 20 = $233.33/month;
Emp + Spouse/Emp + Child(ren)/Family: CDHP 15 = $250.00/month; CDHP 20 = $454.17/month

DENTAL

Option Code	2022 Election (check one) ↓	Plan Name	Single	Emp+sp	Emp+ch	Family
DD 25	☐	Dent&Ortho-25/75	$ 74	$ 148	$ 133	$ 222
DD 50	☐	Basic Dental-50/150	$ 55	$ 110	$ 99	$ 165
DDPV	☐	Preventive Dental	$ 36	$ 72	$ 65	$ 108
	☐	I decline dental coverage.				

DENTAL (check one)	
☐	Single
☐	Employee + spouse
☐	Employee + child(ren)
☐	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:
Christina Butterfield, Senior Accountant
Diocese of Ohio
2230 Euclid Avenue
Cleveland, OH 44115

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