

## 1 Information About the Employee

Title \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_  
 (The Rev., Mr., Mrs., Ms., etc.) Date Hired \_\_\_\_\_  
 \_\_\_\_\_ Years of credited service (retirees only)

## 2 Reasons for and Date of Change

Terminated       Change in billing information       Other significant life change  
 Deceased member       Change in eligibility of dependent  
 Deceased dependent       Transferred from another parish in same diocese  
 Change of Address  
 Early Retirement       Marriage\*  
 Age 65+ retirement       Divorce\*

Change Effective \_\_\_\_\_ Mo/Day/Yr

\*Include copies of legal marriage documents

## 3 Employee's New Address (if applicable)

<p><b>Residence</b></p> <p>Street _____</p> <p>City _____ State _____ Zip _____</p> <p>Home Phone _____ E-mail _____</p>	<p><b>Mailing Address (if different)</b></p> <p>Street _____</p> <p>City _____ State _____ Zip _____</p>
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## 4 Changes in Billing Information (if applicable)

Name of Episcopal Organization _____	Phone _____	E-mail _____	List Bill ID _____
Street _____	City _____	State _____	Zip _____

Bill to Episcopal Organization       Bill directly to Member (Retirees only)       Pension deduction (Retirees only)\*

If billing for retiree and spouse is different, please provide instructions for spouse on a separate sheet.  
 \*If checked, please attach Pension Deduction Form.

## 5 Change in Active Medical Coverage (if applicable)

<input type="checkbox"/> Terminate Medical Coverage  <input type="checkbox"/> Change Medical coverage from (Tier) _____ to (Tier) _____	<input type="checkbox"/> Add or change Medical Plan From _____ Name of Current Plan      Type of Plan (HMO, PPO, etc.) To _____ Name of New Plan      Type of Plan
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(see section 10 for list of tiers; complete section 8 if appropriate)

**6** Change in Active Dental Coverage (if applicable)

Terminate Dental Coverage  Add or change Dental Plan

Change Dental coverage from \_\_\_\_\_  
 (Tier) \_\_\_\_\_ to (Tier) \_\_\_\_\_

(see section 10 for list of tiers; complete section 8 if appropriate)

From \_\_\_\_\_  
 Name of Current Plan      Type of Plan (Basic, Preventive)

To \_\_\_\_\_  
 Name of New Plan      Type of Plan

**7** Change in Retiree Medical Coverage (if applicable)

Terminate Retiree Medical Coverage  Add or change Retiree Medical Plan

Change Retiree Medical coverage from \_\_\_\_\_  
 (Tier) \_\_\_\_\_ to (Tier) \_\_\_\_\_

(see section 10 for list of tiers; complete section 8 if appropriate)  
 If Active Medical Plan chose, please complete Section 5.

From \_\_\_\_\_  
 Name of Current Plan

To \_\_\_\_\_  
 Name of New Plan

**8** Change Dependents (if applicable)\*

Change	Full Name	Relationship	Soc. Sec. No.	Birth Date (M/D/Y)	Gender
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	_____	_____	- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	_____	_____	- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Add <input type="checkbox"/> Cancel	_____	_____	- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F

If you need more space, attach an additional Enrollment Form.  
 \*Dependents 19 and over (full-time students, etc.) may be eligible—check Administrative Guidelines for your diocese or organization. If your group offers domestic partnership coverage, attach supporting documentaion with this form.

**9** 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 \_\_\_\_\_ E-mail \_\_\_\_\_

\*Include Power of Attorney documentation if applicable.

**10** Explanation of Tiers of Coverage

**Tiers for Active Medical and Dental Coverage:\***

Single, employee + 1 (spouse), employee + child, Employee + children, Family

\*All tiers may not be available in your diocese or organization. Contact The Medical Trust with questions.

**Tiers for Retiree Medical Coverage:\***

Single, employee + 1, One Medicare/One Non-Medicare