

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Terminated | <input type="checkbox"/> Change in billing information | <input type="checkbox"/> Other significant life change |
| <input type="checkbox"/> Deceased member | <input type="checkbox"/> Change in eligibility of dependent | _____ |
| <input type="checkbox"/> Deceased dependent | <input type="checkbox"/> Transferred from another parish in same diocese | |
| <input type="checkbox"/> Change of Address | <input type="checkbox"/> Marriage* | |
| <input type="checkbox"/> Early Retirement | <input type="checkbox"/> Divorce* | |
| <input type="checkbox"/> Age 65+ retirement | | |

*Include copies of legal marriage documents

Change Effective _____
Mo/Day/Yr

3 Employee's New Address (if applicable)

Residence

Street _____

 City _____ State _____ Zip _____

 Home Phone _____ E-mail _____

Mailing Address (if different)

Street _____

 City _____ State _____ Zip _____

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

6 Change in Active Dental Coverage (if applicable)

Terminate Dental Coverage

Add or change Dental Plan

Change Dental coverage from
(Tier) _____ to (Tier) _____

From _____
Name of Current Plan Type of Plan (Basic, Preventive)

To _____
Name of New Plan Type of Plan

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

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) _____

From _____
Name of Current Plan

To _____
Name of New Plan

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

If Active Medical Plan chose, please complete Section 5.

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