

Listed below are the health plan choices offered by your group and the associated monthly rates for each, effective January 1, 2026. If you wish to select coverage, please complete the appropriate spaces below and check the box next to your 2026 Health Plan Choices and indicate the Tier (Single, etc.)

Member Information

Name _____

Address _____

City, State Zip _____

Date of Birth _____ Social Security No. _____

Hire Date _____ M ☐ F ☐

Gender _____

Diocese of Alabama**0015**

Group # _____

Medical Billing Unit _____

Employer's Name _____

Employer's Address _____

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).

2026 Health Plan Choices

Option Code	2026 Election (check one)		MEDICAL		MEDICAL (check one)	
	Plan Name		Single	Family	☐ Single ☐ Family	
MHDE	☐	Anthem BCBS CDHP-20/HSA	\$0	\$0	☐ Single ☐ Family	
MPP3	☐	Anthem BCBS BlueCard PPO 80	\$130	\$329		
MPP4	☐	Anthem BCBS BlueCard PPO 70	\$12	\$58		
MS11	☐	Anthem BCBS BlueCard MSP PPO 80	\$839	\$1,930		
MS12	☐	Anthem BCBS BlueCard MSP PPO 70	\$745	\$1,714		
	☐	I decline medical coverage				

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

Employee's Signature _____

Date _____

EMAIL THIS FORM TO: amy_jones@ajg.com

Mail Form to:

Amy Jones

Gallagher Benefit Services

PO Box 190

Selma AL 36702

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 _____