THE EPISCOPAL CHURCH MEDICAL TRUST **2027 GROUP ENROLLMENT FORM**

Listed below are the health plan choices offered by your group and the associated monthly rates for each, effective January 1, 2027. If you wish to select coverage, please complete the appropriate spaces below and check the box next to your 2027 Health Plan Choices and indicate the Tier (Single, etc.)

Member Information

_____
Name

_____
Address

_____
City,State Zip

_____ _____
Date of Birth *Social Security No.*

_____ M ☐ F ☐
Hire Date *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).

2027 Health Plan Choices

MEDICAL

Option Code	Election (check one)	Plan Name	Single	Family
MHDE	☐	Anthem BCBS CDHP-20/HSA	$0	$0
MPP3	☐	Anthem BCBS BlueCard PPO 80	$142	$357
MPP4	☐	Anthem BCBS BlueCard PPO 70	$19	$74
MS11	☐	Anthem BCBS BlueCard MSP PPO 80	$0	$0
MS12	☐	Anthem BCBS BlueCard MSP PPO 70	$0	$0

MEDICAL (check one)

☐ **Single**
☐ **Family**

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 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*