EPISCOPAL CHURCH MEDICAL TRUST
19 East 34th Street
New York, NY 10016
(800) 480-9967
(877) 432-9274 fax
www.cpg.org
email: mtcustserv@cpg.org

United Healthcare

2024 Group Medicare Advantage & Dental Enrollment Form

Personal Information

Title | First | MI | Last | Suffix

Street Address or P.O. Box*

City | State | Zip

*If you have a listed P.O. Box above, one of the following conditions must apply to you.

- ☐ You are in the Address Confidentiality Program.
- ☐ You are in the Witness Protection Program.
- ☐ You are currently homeless.
- ☐ You certify that you also have a permanent address in the US or US territories.
- ☐ You live in a rural area where permanent addresses are not provided (if this scenario applies to you, please include a tax record, utility bill, voter registration record or driver's license that states the county you live in).

If none of the conditions above apply to you, please insert a physical street address above in order to enroll in this plan.

Home Phone | Cell Phone | Email

Date of Birth (month/day/year) | Social Security Number

☐ Male ☐ Female ☐ Clergy ☐ Lay ☐ Married ☐ Single ☐ Surviving spouse/dependent or former spouse of: _____

Spouse/Dependent Information (if applicable)

Title | First | MI | Last | Suffix

Date of Birth (month/day/year) | Social Security Number

Medical Coverage

Plans and monthly premiums are subject to change every January 1.

Please check the box(es) below to indicate who will be receiving coverage.

Group Medicare Advantage (PPO) Plan with Prescription Drug Coverage	Monthly Cost Per Person*	Member	Spouse/ Dependent
GMA Comprehensive (PPO)	$227	☐	☐
GMA Premium (PPO)	$317	☐	☐

**These actual costs do not reflect any subsidy you may be eligible to receive from The Church Pension Fund or your former employer. Some dioceses subsidize the costs for their retirees. Check with your diocese to determine the actual cost for each plan.*

Coverage Effective Date (must be the first day of the month) _____

Note:

- Both UnitedHealthcare Group Medicare Advantage (PPO) plan options include Part D prescription drug coverage. If you enroll in this UnitedHealthcare Group Medicare Advantage (PPO) plan and you have an existing Medicare Part D prescription drug plan not provided by the Episcopal Church Medical Trust (Medical Trust), Medicare may disenroll you from that Medicare Part D plan because you can only be enrolled in one Medicare Part D plan at a time.
- Proof of enrollment in Medicare Part A and Part B is required to participate in a UnitedHealthcare Group Medicare Advantage (PPO) plan. Please attach a copy of your, and/or your spouse's/dependent's Medicare ID card or Social Security Administration letter confirming your Medicare Parts A and Part B enrollment.
- Retirees enrolled in TRICARE For Life can also be enrolled in the UnitedHealthcare Group Medicare Advantage (PPO) plan offered through the Medical Trust plan.
- A spouse/dependent will not be eligible for coverage under the UnitedHealthcare Group Medicare Advantage (PPO) plan if the member is not enrolled in a Medical Trust plan. Eligibility requirements may vary for surviving spouses and former spouses.
- If you are age 65+ but an eligible spouse/dependent is under age 65 and not enrolled in Medicare Part A or Part B *OR* if you are under age 65 but an eligible spouse/dependent is age 65+ and is enrolled in Medicare Part A and Part B, please contact Church Pension Group Client Services at (800) 480-9967, Monday to Friday, 8:30AM to 8:00PM ET.

☐ I Decline Medical Coverage

Dental Coverage

Plans and monthly premiums are subject to change every January 1.

Please check the box(es) below to indicate who will be receiving coverage.

Dental Plan	Monthly Cost Per Person*	Member	Spouse/ Dependent
Delta Dental Basic	$61	☐	☐
Delta Dental Comprehensive	$74	☐	☐
Delta Dental Premium	$90	☐	☐

**These actual costs do not reflect any subsidy you may be eligible to receive from The Church Pension Fund or your former employer. Some dioceses subsidize the costs for their retirees.*

Coverage Effective Date (must be the first day of the month) _____

Note:

- A spouse/dependent will not be eligible for coverage under the Delta Dental plan if the member is not enrolled in a Medical Trust plan. Eligibility requirements may vary for surviving spouses and former spouses.
- Plan rates for a spouse/dependent under age 65 may vary. Please contact the Medical Trust at (800) 480-9967, Monday to Friday, 8:30 AM to 8:00 PM ET.

☐ I Decline Dental Coverage

Billing Information

If you receive a pension from The Church Pension Fund and the monthly pension benefit covers either the full cost of dental, medical or both, the cost of coverage will be deducted from your monthly pension. Otherwise, you will be billed directly. If your employer covers the full cost of dental, medical or both, please indicate below and provide the relevant information so we can bill them.

☐ My Episcopal Institution covers the full cost of my medical and/or dental coverage

If an Episcopal institution will be billed, that institution must complete the section below.

☐ Bill for Medical ☐ Bill for Dental

Name of Institution

List Bill ID # Phone

Street Address

City State Zip

Approval Signature

Title Date

If you receive a monthly pension from The Church Pension Fund that covers the full cost of your dental, medical or both, you agree to the following pension deduction agreement and authorization:

Pension Deduction Agreement and Authorization

As a condition of my enrollment in the health coverage(s) I have selected, I hereby authorize The Church Pension Fund to deduct the amount(s) indicated from my pension benefit and to pay such amount(s) to The Episcopal Church Clergy and Employees' Benefit Trust in respect of my and, if applicable, any eligible dependent's monthly contribution for the health coverage(s) selected on this enrollment form. I acknowledge that participation in this retiree medical program is optional and that I authorize this deduction from my pension benefit voluntarily and without any duress or undue influence by The Episcopal Church Medical Trust or any of its affiliates. I acknowledge that this deduction is for my benefit and that I have received written notice of all terms and conditions of the payment and/or its benefits and the details of the manner in which deductions will be made.

I understand that future cost increases will automatically be withheld from my pension benefit, as long as I remain in the same plan(s) or am defaulted to a replacement plan(s), without additional authorization. I understand that whenever there is a substantial change in the terms or conditions of the payment, including but not limited to any change in the amount of the deduction, or a substantial change in the benefits of the deduction or the details in the manner in which deductions are made, that I will be notified prior to the implementation of the change.

I understand that if I am enrolling with The Episcopal Church Medical Trust for the first time, the first pension deduction may include more than one month's premium.

Please Sign Below

By signing below, I understand and agree that:

- All of the information provided on this form is complete and accurate.
- I have reviewed the benefit plan information, understand the benefit choices available and elect the options above.
- On behalf of my dependents and myself, I agree to abide by the terms of the benefit plans.
- I understand that I cannot change my election during the plan year unless the change is due to a Significant Life Event or HIPAA Special Enrollment Event.
- I understand the plan and premiums will remain in effect from my date of enrollment through the end of the calendar year.
- I agree to the terms and conditions of the Billing Information selection above.
- I am not currently incarcerated in a correctional facility.

Member Signature
Include Power of Attorney documentation if applicable

Signature_____ Date_____

Spouse/Dependent Signature (if applicable)
Include Power of Attorney documentation if applicable

Signature_____ Date_____