



## 2027 New Enrollment/Change Form

### Medical, Dental, EAP, Group Life, Short & LT Disability

*(Please complete only if you are a new enrollee, or have changes to report for Open Enrollment)*

#### 1. CLERGY/LAY EMPLOYEE INFORMATION

|                                                                                                                                 |                              |                                                   |                                                 |
|---------------------------------------------------------------------------------------------------------------------------------|------------------------------|---------------------------------------------------|-------------------------------------------------|
| <u>Name</u>                                                                                                                     |                              | <u>SSN</u>                                        |                                                 |
| <u>Address</u><br><br>                                                                                                          |                              | <u>Phone</u><br><br><u>Email Address</u>          |                                                 |
| <u>Marital Status</u><br><br><input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced | <u>Yearly Salary</u><br><br> | <u>Congregation / City</u><br><br><u>Position</u> | <u>Date of Birth</u><br><br><u>Date of Hire</u> |

#### 2. ENROLLMENT INFORMATION - Please list those you wish to cover under each plan and indicate coverage selected. (30 HRS/WK REQUIREMENT)

| Action                                                                                               | Relation                  | Name | Social Security # / Phone Number / Email   | Date of Birth | Gender | Coverage                                                            |
|------------------------------------------------------------------------------------------------------|---------------------------|------|--------------------------------------------|---------------|--------|---------------------------------------------------------------------|
| <input type="checkbox"/> Continue<br><input type="checkbox"/> Add<br><input type="checkbox"/> Delete | Employee                  |      | SSN: _____<br>Phone: _____<br>Email: _____ |               |        | <input type="checkbox"/> Dental<br><input type="checkbox"/> Medical |
| <input type="checkbox"/> Continue<br><input type="checkbox"/> Add<br><input type="checkbox"/> Delete | Spouse / Domestic Partner |      | SSN: _____<br>Phone: _____<br>Email: _____ |               |        | <input type="checkbox"/> Dental<br><input type="checkbox"/> Medical |
| <input type="checkbox"/> Continue<br><input type="checkbox"/> Add<br><input type="checkbox"/> Delete | Dep                       |      | SSN: _____                                 |               |        | <input type="checkbox"/> Dental<br><input type="checkbox"/> Medical |
| <input type="checkbox"/> Continue<br><input type="checkbox"/> Add<br><input type="checkbox"/> Delete | Dep                       |      | SSN: _____                                 |               |        | <input type="checkbox"/> Dental<br><input type="checkbox"/> Medical |

#### COORDINATION OF BENEFITS

Are you or your dependents covered by any other group health or dental plan?    YES \_\_\_\_\_    NO \_\_\_\_\_

#### 3. DENTAL PLAN SELECTIONS (DELTA DENTAL OF MICHIGAN) (30 HRS/WK REQUIREMENT)

The Insurance Carrier rates are illustrated for your information.

|                                                    |                                                   |                                                                          |                                                                  |                                                    |
|----------------------------------------------------|---------------------------------------------------|--------------------------------------------------------------------------|------------------------------------------------------------------|----------------------------------------------------|
|                                                    | <u>Single</u><br><input type="checkbox"/> \$46.20 | <u>Employee &amp; Spouse/Partner</u><br><input type="checkbox"/> \$87.27 | <u>Employee &amp; Child</u><br><input type="checkbox"/> \$109.55 | <u>Family</u><br><input type="checkbox"/> \$169.25 |
| <input type="checkbox"/> I decline Dental coverage |                                                   |                                                                          |                                                                  |                                                    |

#### 4. Medical Plan Selections (Episcopal Medical Trust)

##### Plan Name

##### 2027 Rates

Single

Plus One

Family

Anthem BCBS BlueCard PPO 80 \*

\$ 1,262 \$ 2,272 \$ 3,534

Anthem BCBS BlueCard PPO 90

\$ 1,485 \$ 2,673 \$ 4,158

Anthem BCBS CDHP-15/HSA \*\*

\$ 1,175 \$ 2,115 \$ 3,290

Anthem BCBS CDHP-20/HSA \*\*

\$ 1,044 \$ 1,879 \$ 2,923

EAP

\$ 4 \$ 4 \$ 4

\*Rate for monthly annuity in lieu of medical insurance

\*\*Plans must be combined with contributions to a Health Savings Account (HSA)

**Medical Plan Selected** \_\_\_\_\_ Single \_\_\_\_\_ Plus One \_\_\_\_\_ Family

*EyeMed Vision Benefits are an included benefit with all Medical Trust health care plans*

#### Employee Assistance Program (EAP) Enrollment - \$4.00 Monthly Premium

☐ Employees must work a minimum of 1000 average annual hours to enroll in the EAP. The EAP is an included benefit with all Medical Trust health care plans. If you are already enrolled in a Medical Trust plan, you will not need this stand-alone EAP.

#### 5. BASIC LIFE / ACCIDENTAL DEATH & DISMEMBERMENT (ADD) INSURANCE (LINCOLN LIFE) – OPTIONAL FOR CLERGY (30 HRS/WK REQUIREMENT)

☐ Basic Life / AD&D Insurance amount equal to 2x your base annual earnings up to a maximum of \$100,000 is provided at no cost to you. The premiums are paid by your employer.

☐ You may insure your spouse and dependents with a benefit of \$5,000 each. The monthly premium is an additional \$2.89 total, regardless of the number of dependents. Children must be under age 19, or age 26, if a full-time student.

|                       | Enroll | Decline | Name  | DOB   |
|-----------------------|--------|---------|-------|-------|
| Basic Life – Spouse   | _____  | _____   | _____ | _____ |
| Basic Life Child(ren) | _____  | _____   | _____ | _____ |
|                       |        |         | _____ | _____ |

Use additional sheet if necessary.

#### BASIC LIFE INSURANCE BENEFICIARY

I designate the person(s) named below as beneficiary of any life insurance benefits payable upon my death as outlined under the terms of the plan. If more than one beneficiary is named, the death benefit, unless otherwise provided herein, will be paid in equal shares to the designated beneficiaries who survive the associate. If no such beneficiary survives, payment will be made in accordance with the terms of the policy.

| Life Insurance <b>Primary</b> Beneficiary - Individual or Trust  |               |              | Percentage Share<br>(must total 100%) |
|------------------------------------------------------------------|---------------|--------------|---------------------------------------|
| Name                                                             | Date of Birth | Relationship |                                       |
| Name                                                             | Date of Birth | Relationship |                                       |
| Life Insurance <b>Secondary</b> Beneficiary- Individual or Trust |               |              |                                       |
| Name                                                             | Date of Birth | Relationship |                                       |
| Name                                                             | Date of Birth | Relationship |                                       |

**6. SHORT TERM DISABILITY (STD) INSURANCE (LINCOLN LIFE) (30 HRS/WK REQUIREMENT)**

\_\_\_\_\_ I work an average of 1500 hours or more annually.

Lay employees working 1500 hours or more annually are provided a STD benefit insured by Lincoln Life. The benefit amount is equal to 70% of your base weekly earnings to a maximum of \$1,500 per week.

**7. LONG TERM DISABILITY (LTD) INSURANCE (LINCOLN LIFE) (30 HRS/WK REQUIREMENT)**

\_\_\_\_\_ I work an average of 1500 hours or more annually.

Lay employees working 1500 hours or more annually are provided a LTD benefit equal to 60% of your base monthly earnings to a maximum of \$6,000 per month. Benefit begins on the 91st day of disability. Please see your Lincoln Life booklet for more details.

Note: All active diocesan clergy are covered for short-term and long-term disability through the Church Pension Fund.  
Please contact Crystal Ramirez (cramirez@edomi.org) for clarification.

**AUTHORIZATION**

I have read the enrollment materials and I have indicated my elections on this form. I understand that should I waive coverage my next opportunity to enroll in the benefit plans will be **November 1, 2028**, unless I have a qualified family status change as addressed in the benefit guide. Please sign and date below and make a copy for your records.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please return form to [cramirez@edomi.org](mailto:cramirez@edomi.org)