



445 Fifth Avenue  
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 www.cpg.org

## Employee Group Medical and Dental Enrollment Form

### 1 Information About the Employee

- New Employee (See Enrollment Guidelines on back)  
 Late Enrollment (Include Health Statement)  
 \_\_\_\_\_ Years of credited service (retirees only)

Date Hired     /    /     Coverage Effective     /    /      
 Mo / Day / Yr Mo / Day / Yr

Birth Date     /    /     Soc. Sec. No.     -    -      
 Mo / Day / Yr

Title First Name M.I. Last Name  
 (The Rev., Mr., Mrs., Ms., etc.)

#### Residence

#### Mailing Address (if different)

Street \_\_\_\_\_

Street \_\_\_\_\_

City State Zip

City State Zip

Home Phone E-mail

- Male  Married  Clergy  
 Female  Single  Lay

Seminarian

### 2 Billing Information for Medical and Dental Plans

Name of Organization Phone E-mail List Bill ID

Street City State Zip

#### Billing Instructions:

Send bill to the attention of \_\_\_\_\_

### 3 Active Medical Coverage

Medical coverage declined

Name of Plan Carrier Type of Plan (HMO, PPO, etc.)

Tier:  Single  Employee + 1 (spouse)  
 Employee + child  Employee + children  Family

### 4 Dental Coverage

Dental coverage declined

Name of Plan Carrier Type of Plan (Preventative, \$25, \$50, etc.)

Tier:  Single  Employee + 1 (spouse)  
 Employee + child  Employee + children  Family

### 5 Retiree Medical Coverage

Name of Plan Choice Retirement Date (Mo/Day/Yr)  
 for Retiree

Name of Plan Choice Date of Marriage (Mo/Day/Yr)\*  
 for Spouse

\*Include copies of legal marriage documents

**6** Information About Your Dependents

List dependents and check coverage desired. 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 documentation with this form. For more space, attach an additional Enrollment Form.

Coverage	Full Name	Relationship	Soc. Sec. No.	Birth Date (M/D/Y)	Gender
<input type="checkbox"/> Medical <input type="checkbox"/> Dental			- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Medical <input type="checkbox"/> Dental			- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Medical <input type="checkbox"/> Dental			- -	/ /	<input type="checkbox"/> M <input type="checkbox"/> F

**7** 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.

**8** Enrollment Guidelines

- For Group Medical Benefits, if the Health Insurance Portability and Accountability Act of 1996 (HIPAA) applies, you must include evidence of your prior health coverage with this form.
- New employees must enroll and sign this form within 30 days of hire or eligibility date for Group Medical/Dental Insurance.
- If enrolling in a Managed Care Plan, attach Managed Care application. Managed Care plans do not accept late enrollments.
- All late enrollments subject to approval.