

Listed below are the health plan choices offered by your group and the associated monthly rates for each. If you wish to select coverage, please complete the appropriate spaces below and check the box next to your 2017 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 Minnesota

0510
 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).

2017 Health Plan Choices

		<u>MEDICAL</u>			MEDICAL (check one)
Option Code	2017 Election (check one) Plan Name	Single	Emp+1	Family	
MEAP	<input type="checkbox"/> EAP	\$5	\$5	\$5	<input type="checkbox"/> Single <input type="checkbox"/> Emp+1 <input type="checkbox"/> Family
MHDE	<input type="checkbox"/> Anthem BCBS CDHP-20/HSA	\$562	\$1,012	\$1,574	
MSG3	<input type="checkbox"/> Anthem PPO MS 80/60	\$641	\$1,154	\$1,795	
MSP0	<input type="checkbox"/> Anthem PPO 90/70	\$844	\$1,519	\$2,363	
MSPZ	<input type="checkbox"/> Anthem PPO 80/60	\$753	\$1,355	\$2,108	
	<input type="checkbox"/> I decline medical coverage				

		<u>DENTAL</u>			DENTAL (check one)
Option Code	2017 Election (check one) Plan Name	Single	Emp+1	Family	
DD25	<input type="checkbox"/> Dent&Ortho-25/75	\$59	\$106	\$165	<input type="checkbox"/> Single <input type="checkbox"/> Emp+1 <input type="checkbox"/> Family
	<input type="checkbox"/> I decline dental coverage				

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

 Employee's Signature

 Date

MAIL THIS FORM TO:

Elizabeth Geno
 Diocese of Minnesota
 1730 Clifton Pl Ste 201
 Minneapolis, MN 55403-3242

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