THE EPISCOPAL CHURCH MEDICAL TRUST **2026 GROUP ENROLLMENT FORM**

Listed below are the health plan choices offered by your group and the associated monthly rates for each, effective January 1, 2026. If you wish to select coverage, please complete the appropriate spaces below and check the box next to your 2026 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 Connecticut

0147 *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).

2026 Health Plan Choices

MEDICAL

Option Code	2026 Election (check one) Plan Name	Single	Emp+1	Family
MG01	☐ Cigna Open Access Plus PPO 100	$1,727	$3,109	$4,836
MG02	☐ Cigna Open Access Plus PPO 90	$1,479	$2,662	$4,141
MG03	☐ Cigna Open Access Plus PPO 80	$1,294	$2,329	$3,623
MGM1	☐ Cigna Open Access Plus MSP PPO 100	$1,382	$2,488	$3,870
MGM2	☐ Cigna Open Access Plus MSP PPO 90	$1,183	$2,129	$3,312
MGM3	☐ Cigna Open Access Plus MSP PPO 80	$1,033	$1,859	$2,892
MHDC	☐ Cigna Open Access Plus CDHP-20/HSA	$1,074	$1,933	$3,007
MHDE	☐ Anthem BCBS CDHP-20/HSA	$1,074	$1,933	$3,007
MPP1	☐ Anthem BCBS BlueCard PPO 100	$1,727	$3,109	$4,836
MPP2	☐ Anthem BCBS BlueCard PPO 90	$1,479	$2,662	$4,141
MPP3	☐ Anthem BCBS BlueCard PPO 80	$1,294	$2,329	$3,623
MS10	☐ Anthem BCBS BlueCard MSP PPO 90	$1,183	$2,129	$3,312
MS11	☐ Anthem BCBS BlueCard MSP PPO 80	$1,033	$1,859	$2,892
MSG9	☐ Anthem BCBS BlueCard MSP PPO 100	$1,382	$2,488	$3,870
	☐ I decline medical coverage			

MEDICAL (check one)
☐ Single
☐ Emp+1
☐ Family

DENTAL

Option Code	2026 Election (check one) Plan Name	Single	Emp+1	Family
DCOM	☐ Delta Dental Comprehensive	$59	$106	$165
DDBA	☐ Delta Dental Basic	$44	$79	$123
DPRE	☐ Delta Dental Premium	$77	$139	$216
	☐ I decline dental coverage			

DENTAL (check one)
☐ Single
☐ Emp+1
☐ Family

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:

Kathleen O'Hearn
Diocese of Connecticut

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*