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

For Office Use Only
Years of Service _____
Clergy Eligible for Subsidy _____
Spouse Eligible for Subsidy _____

2021 Retiree Medicare Supplement & Dental Enrollment Form

Personal Information

Title First Name M.I. Last Name Suffix

Birth Date (mo/day/yr) Social Security Number

☐ Retiree ☐ Spouse
☐ Surviving Spouse of _____

Clergy ID Number _____

☐ Clergy ☐ Married ☐ Male
☐ Lay ☐ Single ☐ Female

Former Employer/Diocese _____

Years of Credited Service _____

Retirement Date _____

Street Address

City State Zip

Home Phone

Email

Spouse

Title First Name M.I. Last Name Suffix

Birth Date (mo/day/yr) Social Security Number

Medical Coverage

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

Medicare Supplement Plan	Monthly Cost Per Person*	Member	Spouse
With Prescription Drug Coverage			
Comprehensive	$400	☐	☐
Plus	$520	☐	☐
Premium	$605	☐	☐
Without Prescription Drug Coverage			
Comprehensive II**	$215	☐	☐
Plus II**	$250	☐	☐
Premium II**	$300	☐	☐

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

☐ Medical Coverage Declined

☐ Terminate Existing Medical Coverage as of (must be the last day of the month) _____

Note: Proof of enrollment in Medicare Part A and Part B is required to participate in a Medical Trust Medicare Supplement plan, but it is NOT required to enroll in our dental plans. Please attach a copy of your Medicare ID card or Social Security Administration letter confirming your Medicare Parts A & B enrollment.

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

*** These plans are only available if you are enrolled in a Medicare Part D prescription drug plan. Please attach a copy of your Medicare Part D card in addition to your Medicare ID card.*

Dental Coverage

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

Dental Plan	Monthly Cost Per Person	Member	Spouse
Preventive Dental Plan	$61	☐	☐
Basic Dental Plan	$74	☐	☐
Dental and Orthodontia Plan	$90	☐	☐

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

☐ Dental Coverage Declined

☐ Terminate Existing Dental Coverage as of (must be the last day of the month) _____

(Note: No mid-year cancellation of the dental plan is permitted. If you enroll, the plan and premiums will remain in effect from your date of enrollment through the end of the calendar year.)

Billing Information

☐ Bill Me Directly ☐ Pension Deduction from My Pension Check ☐ Bill to Episcopal Organization

Pension Deduction Agreement and Authorization

☐ I authorize the Church Pension Fund to deduct the amount indicated below from my pension benefit, payable to the Episcopal Church Clergy and Employees' Benefit Trust, as my monthly contribution for the health coverage(s) selected on this enrollment form. I understand that future cost increases will automatically be withheld from my pension benefit, as long as I remain in the same plan(s), without additional authorization. I understand I will be notified annually of any increase in premiums and/or changes to the plans. _____
Please Initial

☐ As of the coverage effective date(s), I will pay $_____ per month for:

☐ Medical ☐ Dental *for the coverage applicable to*: ☐ Me ☐ My Spouse & Me ☐ My Spouse

I understand that if I am enrolling with the Medical Trust for the first time, I must enclose a check to cover the Plan premium(s) for the first two months, and the pension deduction will start in the third month. _____
Please Initial

Health Plan Subsidy

If an Episcopal Institution will be billed, please have that institution complete the section below.

Name of Episcopal Institution	List Bill ID #		Phone #
Street Address	City	State	Zip
Approval Signature from the Institution	Title		Date

Signature

Please sign this form indicating that you have made the elections identified on this form. If you elected to have a pension deduction, please initial in the spaces indicated in that section. If your former employer will be contributing to the cost of your coverage, an authorized representative from that institution must sign above.

Member Signature* Date

* Include Power of Attorney documentation if applicable