



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

## 2010 Retiree Enrollment Form Medicare Supplement & Dental

### Personal Information

Title First Name M.I. Last Name Suffix

Street Address

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

City State Zip

Retiree     Spouse  
 Surviving Spouse of \_\_\_\_\_

Home Phone

Clergy ID Number \_\_\_\_\_

Email

Clergy     Married     Male  
 Lay        Single        Female

\_\_\_\_\_ Spouse

Former Employer/Diocese \_\_\_\_\_

Title First Name M.I. Last Name Suffix

Years of Credited Service \_\_\_\_\_

Retirement Date \_\_\_\_\_

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

### Medical Coverage

*Plans and monthly premiums are subject to change every January 1<sup>st</sup>.*

<u>Medicare Supplement Plan</u>	<u>Monthly Cost Per Person*</u>	<u>Member</u>	<u>Spouse</u>
<b><i>With Prescription Drug Coverage</i></b>			
Comprehensive	\$265	<input type="checkbox"/>	<input type="checkbox"/>
Plus	\$350	<input type="checkbox"/>	<input type="checkbox"/>
Premium	\$400	<input type="checkbox"/>	<input type="checkbox"/>
<b><i>Without Prescription Drug Coverage</i></b>			
Comprehensive II**	\$145	<input type="checkbox"/>	<input type="checkbox"/>
Plus II**	\$165	<input type="checkbox"/>	<input type="checkbox"/>
Premium II**	\$210	<input type="checkbox"/>	<input type="checkbox"/>

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 1<sup>st</sup>.

<u>Dental Plan</u>	<u>Monthly Cost Per Person</u>	<u>Member</u>	<u>Spouse</u>
Preventive Dental Plan	\$25	<input type="checkbox"/>	<input type="checkbox"/>
Basic Dental Plan	\$51	<input type="checkbox"/>	<input type="checkbox"/>
Dental and Orthodontia Plan	\$65	<input type="checkbox"/>	<input type="checkbox"/>

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