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

## 2008 Enrollment Form: Retiree Group Medical and Dental

### 1 Personal Information

<table border="0" style="width: 100%;"> <tr> <td style="width: 15%;">Title</td> <td style="width: 25%;">First Name</td> <td style="width: 10%;">M.I.</td> <td style="width: 50%;">Last Name</td> </tr> <tr> <td colspan="2">Birth Date (mo/day/yr)</td> <td colspan="2">Social Security Number</td> </tr> <tr> <td colspan="4"> <input type="checkbox"/> Retiree   <input type="checkbox"/> Spouse of early retiree         </td> </tr> <tr> <td colspan="4"> <input type="checkbox"/> Surviving spouse of: _____         </td> </tr> <tr> <td colspan="4">Clergy ID Number _____</td> </tr> <tr> <td><input type="checkbox"/> Clergy</td> <td><input type="checkbox"/> Married</td> <td colspan="2"><input type="checkbox"/> Male</td> </tr> <tr> <td><input type="checkbox"/> Lay</td> <td><input type="checkbox"/> Single</td> <td colspan="2"><input type="checkbox"/> Female</td> </tr> <tr> <td colspan="4">Former Employer/Diocese _____</td> </tr> <tr> <td colspan="4">Years of Credited Service _____</td> </tr> <tr> <td colspan="4">Retirement Date _____</td> </tr> </table>	Title	First Name	M.I.	Last Name	Birth Date (mo/day/yr)		Social Security Number		<input type="checkbox"/> Retiree <input type="checkbox"/> Spouse of early retiree				<input type="checkbox"/> Surviving spouse of: _____				Clergy ID Number _____				<input type="checkbox"/> Clergy	<input type="checkbox"/> Married	<input type="checkbox"/> Male		<input type="checkbox"/> Lay	<input type="checkbox"/> Single	<input type="checkbox"/> Female		Former Employer/Diocese _____				Years of Credited Service _____				Retirement Date _____				<p><b>Address</b></p> <p>Street _____</p> <p>City _____ State _____ Zip _____</p> <p>Home Phone _____</p> <p>E-mail _____</p> <p><b>Spouse</b></p> <table border="0" style="width: 100%;"> <tr> <td style="width: 15%;">Title</td> <td style="width: 25%;">First Name</td> <td style="width: 10%;">M.I.</td> <td style="width: 50%;">Last Name</td> </tr> <tr> <td colspan="2">Birth Date (mo/day/yr)</td> <td colspan="2">Social Security Number</td> </tr> </table>	Title	First Name	M.I.	Last Name	Birth Date (mo/day/yr)		Social Security Number	
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### 2 Medical Coverage *(Plans and monthly costs are subject to change every January 1st.)*

Plan Name	Monthly Cost Per Individual*	Member	Spouse
Premium Plan	\$360	<input type="checkbox"/>	<input type="checkbox"/>
Plus Plan	\$325	<input type="checkbox"/>	<input type="checkbox"/>
Comprehensive Plan	\$250	<input type="checkbox"/>	<input type="checkbox"/>
Premium Plan II**	\$184	<input type="checkbox"/>	<input type="checkbox"/>
Plus Plan II**	\$145	<input type="checkbox"/>	<input type="checkbox"/>
Comprehensive Plan II**	\$125	<input type="checkbox"/>	<input type="checkbox"/>

**Coverage Effective Date** (must be first day of the month) \_\_\_\_\_

- Medical Coverage Declined
- Terminate Existing Medical Coverage as of (must be last day of the month) \_\_\_\_\_

Enrollment in Medicare Part A and Part B is required for these plans. Please attach a copy of your Medicare card or the letter from Social Security confirming your Part A and Part B enrollment.

\* Costs indicated above are actual costs and do not reflect any subsidy amount you may be receiving from your former employer. If you are receiving a subsidy from your former employer, please contact them to determine if the amount is changing for 2008.

\*\* These plans do not include prescription drug benefits and are available only if you are enrolled in a Medicare Part D prescription drug plan. Please attach a copy of your Medicare card and your Medicare Part D card.

