

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 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 New York**0604**

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)		<u>MEDICAL</u>			MEDICAL (check one)	
	Plan Name		Single	Emp+1	Family		
MEAP	<input type="checkbox"/> EAP		\$4	\$4	\$4	<input type="checkbox"/> Single	
MG01	<input type="checkbox"/> Cigna Open Access Plus PPO 100		\$1,717	\$3,091	\$4,808	<input type="checkbox"/> Emp+1	
MG03	<input type="checkbox"/> Cigna Open Access Plus PPO 80		\$1,283	\$2,309	\$3,592	<input type="checkbox"/> Family	
MGM1	<input type="checkbox"/> Cigna Open Access Plus MSP PPO 100		\$1,374	\$2,630	\$3,847		
MGM3	<input type="checkbox"/> Cigna Open Access Plus MSP PPO 80		\$1,039	\$1,870	\$2,909		
MHDC	<input type="checkbox"/> Cigna Open Access Plus CDHP-20/HSA		\$977	\$1,759	\$2,736		
MHDE	<input type="checkbox"/> Anthem BCBS CDHP-20/HSA		\$977	\$1,759	\$2,736		
MPP1	<input type="checkbox"/> Anthem BCBS BlueCard PPO 100		\$1,717	\$3,091	\$4,808		
MPP3	<input type="checkbox"/> Anthem BCBS BlueCard PPO 80		\$1,283	\$2,309	\$3,592		
MS11	<input type="checkbox"/> Anthem BCBS BlueCard MSP PPO 80		\$1,039	\$1,870	\$2,909		
MSG9	<input type="checkbox"/> Anthem BCBS BlueCard MSP PPO 100		\$1,374	\$2,630	\$3,847		
	<input type="checkbox"/> I decline medical coverage						

DENTAL

Option Code	2026 Election (check one)		<u>DENTAL</u>			DENTAL (check one)	
	Plan Name		Single	Emp+1	Family		
DCOM	<input type="checkbox"/> Delta Dental Comprehensive		\$70	\$126	\$196	<input type="checkbox"/> Single	
DDBA	<input type="checkbox"/> Delta Dental Basic		\$40	\$72	\$112	<input type="checkbox"/> Emp+1	
DPRE	<input type="checkbox"/> Delta Dental Premium		\$87	\$157	\$244	<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

EMAIL THIS FORM TO:

Sara Saavedra
Diocese of New York

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.

Sara Saavedra

Administrator's Signature

Date