

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 _____

Salary: _____ Housing Provided: __ Yes __ No

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).

2027 Health Plan Choices**MEDICAL**

Option Code	2027 Election (check one) Plan Name	Single	Emp+1	Family	MEDICAL (check one) ↓ ☐ Single ☐ Emp+1 ☐ Family
MEAP	☐ EAP	\$4	\$4	\$4	
MG01	☐ Cigna Open Access Plus PPO 100	\$1,957	\$3,523	\$5,480	
MG03	☐ Cigna Open Access Plus PPO 80	\$1,463	\$2,633	\$4,096	
MGM1	☐ Cigna Open Access Plus MSP PPO 100	\$1,566	\$2,819	\$4,385	
MGM3	☐ Cigna Open Access Plus MSP PPO 80	\$1,184	\$2,131	\$3,315	
MHDC	☐ Cigna Open Access Plus CDHP-20/HSA	\$1,133	\$2,039	\$3,172	
MHDE	☐ Anthem BCBS CDHP-20/HSA	\$1,133	\$2,039	\$3,172	
MPP1	☐ Anthem BCBS BlueCard PPO 100	\$1,957	\$3,523	\$5,480	
MPP3	☐ Anthem BCBS BlueCard PPO 80	\$1,463	\$2,633	\$4,096	
MS11	☐ Anthem BCBS BlueCard MSP PPO 100	\$1,566	\$2,819	\$4,385	
MSG9	☐ Anthem BCBS BlueCard MSP PPO 80	\$1,184	\$2,131	\$3,315	
☐ I decline medical coverage					

DENTAL

Option Code	2027 Election (check one) Plan Name	Single	Emp+1	Family	DENTAL (check one) ↓ ☐ Single ☐ Emp+1 ☐ Family
DCOM	☐ Delta Dental Comprehensive	\$71	\$128	\$199	
DDBA	☐ Delta Dental Basic	\$41	\$74	\$115	
DPRE	☐ Delta Dental Premium	\$89	\$160	\$249	
☐ 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