



CHURCH PENSION GROUP

445 Fifth Avenue
 New York, NY 10016
 Active Member Services: 800.480.9967
 Retiree Member Services: 866.273.4545
 Fax (both): 212.592.9499
 www.cpg.org

The Episcopal Church Medical Trust
 Church Life Insurance Corporation

Group Medical, Dental and Disability Insurance Change Form

1 Information About the Employee

Title _____ First Name _____ M.I. _____ Last Name _____
 (The Rev., Mr., Mrs., Ms., etc.)

Soc. _____ - _____ Date _____ / _____ / _____
 Sec. No. _____ Hired Mo / Day / Yr

_____ Years of credited service (retirees only)

2 Reasons for / Date of Change

Terminated Change in billing information Other significant life change
 Deceased member Change in eligibility of dependent
 Deceased dependent Transferred from another parish _____
 Change of address _____ in same diocese
 Early retirement Marriage*
 Age 65+ retirement Divorce* _____

*Attach copies of legal marriage or divorce documents

Change _____ / _____ / _____
 Effective Mo / Day / Yr

3 Employee's New Address (if applicable)

<p>Residence</p> <p>Street _____</p> <p>City _____ State _____ Zip _____</p> <p>Home Phone _____ E-mail _____</p>	<p>Mailing Address (if different)</p> <p>Street _____</p> <p>City _____ State _____ Zip _____</p>
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4 Changes in Billing Information (if applicable)

Medical Plans Dental Plans Disability Plans

Name of Episcopal Organization _____ Phone _____ E-mail _____ List Bill ID _____

Street _____ City _____ State _____ Zip _____

Bill to Episcopal Organization Bill directly to Member (Retirees only) Pension deduction (Retirees only)*
 If billing for retiree and spouse is different, please provide instructions for spouse on a separate sheet.
 *If checked, please attach Pension Deduction Form.

5 Change in Active Medical Coverage (if applicable)

Terminate Medical coverage Add or change Medical Plan

Change Medical coverage from _____
 (Tier) _____ to (Tier) _____
 (see section 11 for list of tiers; complete section 8 if appropriate)

From _____
 Name of Current Plan Type of Plan (HMO, PPO, etc.)

To _____
 Name of New Plan Type of Plan

6 Change in Active Dental Coverage (if applicable)

Terminate Dental coverage Add or change Dental Plan

Change Dental coverage from _____
 (Tier) _____ to (Tier) _____
 (see section 11 for list of tiers; complete section 8 if appropriate)

From _____
 Name of Current Plan Type of Plan (Preventative, \$25, \$50, etc.)

To _____
 Name of New Plan Type of Plan

