



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

*Attach copies of legal marriage or divorce documents

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

3 Employee's New Address (if applicable)

Residence

Street _____
 City _____ State _____ Zip _____
 Home Phone _____ E-mail _____

Mailing Address (if different)

Street _____
 City _____ State _____ Zip _____

4 Changes in Billing Information (if applicable)

- Medical Plans
- Dental Plans
- Disability Plans

Name of Episcopal Organization _____
 Street _____

Phone _____ E-mail _____ List Bill ID _____
 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
- Change Medical coverage from (Tier) _____ to (Tier) _____
(see section 11 for list of tiers; complete section 8 if appropriate)
- Add or change Medical Plan
- 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
- Change Dental coverage from (Tier) _____ to (Tier) _____
(see section 11 for list of tiers; complete section 8 if appropriate)
- Add or change Dental Plan
- From _____ Name of Current Plan Type of Plan (Preventative, \$25, \$50, etc.)
- To _____ Name of New Plan Type of Plan

