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 2017 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 Northwest Texas

0680 *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).

2018 Health Plan Choices

MEDICAL

Option Code	2018 Election (check one) Plan Name	Single	Emp+1	Emp+chd	Family
MEA	☐ EAP	$5	$5	$5	$5
MHBR	☐ Anthem BCBS CDHP-40/HSA	$561	$1,122	$1,010	$1,683
MHDE	☐ Anthem BCBS CDHP-20/HSA	$620	$1,240	$1,116	$1,860
MHDG	☐ Anthem BCBS CDHP-15/HSA	$692	$1,384	$1,246	$2,076
MSP0	☐ Anthem PPO 90/70	$903	$1,806	$1,625	$2,709
MSPZ	☐ Anthem PPO 80/60	$867	$1,734	$1,561	$2,601
MSPV	☐ Anthem PPO 75/50	$748	$1,496	$1,346	$2,244

MEDICAL (check one)

☐ Single
☐ Emp+1
☐ Emp+chd
☐ Family

☐ I decline medical coverage

When you have made your decision, sign and return this form to your administrator as indicated below.

Employee's Signature *Date*

MAIL THIS FORM TO:

Anna Mora
Diocese of Northwest Texas
1802 Broadway
Lubbock, TX 79401-3016

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.

Administrator's Signature *Date*