

Listed below are the health plan choices offered by your group and the associated monthly rates for each, effective January 1, 2024. If you wish to select coverage, please complete the appropriate spaces below and check the box next to your 2024 Health Plan Choices and indicate the Tier (Single, etc.)

Member Information

Name _____
 Address _____
 City, State Zip _____
 Date of Birth _____ Social Security No. _____
 Hire Date _____ Gender M F

Diocese of New Jersey

0581
 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).

2024 Health Plan Choices

Option Code	2024 Election (check one)	Plan Name	MEDICAL				MEDICAL (check one)
			Single	Emp+1	Emp+chd	Family	
MCDG	<input type="checkbox"/>	Cigna Open Access Plus CDHP-40/HSA	\$759	\$1,518	\$1,366	\$2,277	<input type="checkbox"/> Single <input type="checkbox"/> Emp+1 <input type="checkbox"/> Emp+chd <input type="checkbox"/> Family
MCDH	<input type="checkbox"/>	Cigna Open Access Plus CDHP-15/HSA	\$978	\$1,956	\$1,760	\$2,934	
MG01	<input type="checkbox"/>	Cigna Open Access Plus PPO 100	\$1,244	\$2,488	\$2,239	\$3,732	
MG02	<input type="checkbox"/>	Cigna Open Access Plus PPO 90	\$1,136	\$2,272	\$2,045	\$3,408	
MG03	<input type="checkbox"/>	Cigna Open Access Plus PPO 80	\$1,030	\$2,060	\$1,854	\$3,090	
MGM1	<input type="checkbox"/>	Cigna Open Access Plus MSP PPO 100	\$985	\$1,970	\$1,773	\$2,955	
MGM2	<input type="checkbox"/>	Cigna Open Access Plus MSP PPO 90	\$908	\$1,816	\$1,634	\$2,724	
MGM3	<input type="checkbox"/>	Cigna Open Access Plus MSP PPO 80	\$825	\$1,650	\$1,485	\$2,475	
MHBR	<input type="checkbox"/>	Anthem BCBS CDHP-40/HSA	\$759	\$1,518	\$1,366	\$2,277	
MHDC	<input type="checkbox"/>	Cigna Open Access Plus CDHP-20/HSA	\$809	\$1,618	\$1,456	\$2,427	
MHDE	<input type="checkbox"/>	Anthem BCBS CDHP-20/HSA	\$809	\$1,618	\$1,456	\$2,427	
MHDG	<input type="checkbox"/>	Anthem BCBS CDHP-15/HSA	\$978	\$1,956	\$1,760	\$2,934	
MPP1	<input type="checkbox"/>	Anthem BCBS BlueCard PPO 100	\$1,244	\$2,488	\$2,239	\$3,732	
MPP2	<input type="checkbox"/>	Anthem BCBS BlueCard PPO 90	\$1,136	\$2,272	\$2,045	\$3,408	
MPP3	<input type="checkbox"/>	Anthem BCBS BlueCard PPO 80	\$1,030	\$2,060	\$1,854	\$3,090	
MS10	<input type="checkbox"/>	Anthem BCBS BlueCard MSP PPO 90	\$908	\$1,816	\$1,634	\$2,724	
MS11	<input type="checkbox"/>	Anthem BCBS BlueCard MSP PPO 80	\$825	\$1,650	\$1,485	\$2,475	
MSG9	<input type="checkbox"/>	Anthem BCBS BlueCard MSP PPO 100	\$985	\$1,970	\$1,773	\$2,955	
	<input type="checkbox"/>	I decline medical coverage					

Option Code	2024 Election (check one)	Plan Name	DENTAL				DENTAL (check one)
			Single	Emp+1	Emp+chd	Family	
DCOM	<input type="checkbox"/>	Delta Dental Comprehensive	\$65	\$130	\$117	\$195	<input type="checkbox"/> Single <input type="checkbox"/> Emp+1 <input type="checkbox"/> Emp+chd <input type="checkbox"/> Family
DDBA	<input type="checkbox"/>	Delta Dental Basic	\$54	\$108	\$97	\$162	
DPRE	<input type="checkbox"/>	Delta Dental Premium	\$100	\$200	\$180	\$300	
	<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

MAIL THIS FORM TO:

Patricia Hawkins
 Diocese of New Jersey
 Attn: Accounts Payable
 808 W State St
 Trenton, NJ 08618-5326

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