ENROLLMENT AND/OR CHANGE FORM

IMPORTANT: Please print or type neatly.
Incomplete or unclear information will delay enrollment.

60 Boulevard of the Allies, 5th Floor
Pittsburgh, PA 15222
Email: EPC@cdsadmin.com
Fax: 412-224-4465
Phone: 877-578-8707

For information regarding your Plan of Benefits, eligibility or the effective date of coverage please refer to www.epc.org/benefits
Participant Information: All fields must be completed by the Participant and verified by the Church except for those unaffiliated with a Church.

Last Name	First Name	M.I.	Gender	Birth date	Social Security Number	Day Time Phone Number	
Address					City	State	Zip Code
E-Mail Address	Classification: ☐ 1. EPC Ordained Minister ☐ 2. Other EPC Ordained ☐ 3. Mgmt-non-Ordained ☐ 4. Salary Emp ☐ 5. Hourly Emp Job Title:						
Reason for Enrollment:							
☐ New Hire ☐ Add Dependent ☐ Open Enrollment	☐ Transfer from another EPC Church List Name of Prior EPC Church				☐ Enrollment for loss of other coverage *Please provide proof of loss of creditable coverage with this form*	☐ Transfer from another Denomination	
Reason for Change:							
☐ Termination of Employment ☐ Death ☐ Address Change	☐ Retirement ☐ Voluntary Termination				☐ Transfer to another Church List Name and Billing Pin of new Church	☐ Electing other coverage	

LIST ALL DEPENDENTS TO BE COVERED BY THIS ENROLLMENT (provide a second form for additional dependents)
***(The Plan must be notified within 30 days of qualified event for new dependents)**

Relationship	First Name	Middle Initial	Last Name (if different than the Participant)	Social Security Number	Sex M	Sex F	Birthdate Mo/Day/Yr	Dependent 19 or older FTS	Dependent 19 or older DD
Spouse					☐	☐			
*Dependent					☐	☐		☐	☐
*Dependent					☐	☐		☐	☐
*Dependent					☐	☐		☐	☐

Medical Plan - ☐ I decline the Medical Plan Coverage

☐ Platinum	☐ Single ☐ Couple ☐ Family ☐ EE & Children
☐ Gold	☐ Single ☐ Couple ☐ Family ☐ EE & Children
☐ Silver	☐ Single ☐ Couple ☐ Family ☐ EE & Children
☐ Gold HSA	☐ Single ☐ Couple ☐ Family ☐ EE & Children

Dental Plan - ☐ I decline the Dental Plan Coverage

☐ Low Plan	☐ Single ☐ Couple ☐ Family ☐ EE & Children
☐ High Plan	☐ Single ☐ Couple ☐ Family ☐ EE & Children

Vision Plan - ☐ I decline the Vision Plan Coverage

☐ Vision	☐ Single ☐ Couple ☐ Family ☐ EE & Children

TO BE COMPLETED BY CHURCH OFFICER

Life Insurance	☐ Elect ☐ Decline	**Long Term Disability**	☐ Elect ☐ Decline
EE Date of Hire:	Effective Date of Change:	Employee Salary:	
Customer Number from Invoice (Existing EPC Churches only) :			
Church Name (Employer):			
Church City, State, Zip Code:			
Church Daytime Phone Number:		Church Contact Email:	
Church Officer Signature:			
Date:			

Employee Signature _____ **Date**_____