

Listed below are the health plan choices offered by your group and the associated monthly rates for each, effective January 1, 2025. If you wish to select coverage, please complete the appropriate spaces below and check the box next to your 2025 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).

**2025 Health Plan Choices**

2025 Election (check one)		<b>MEDICAL</b>				MEDICAL (check one)
Option Code	Plan Name	Single	Emp+1	Emp+chd	Family	
MG01	<input type="checkbox"/> Cigna Open Access Plus PPO 100	\$1,400	\$2,800	\$2,520	\$4,200	<input type="checkbox"/> Single <input type="checkbox"/> Emp+1 <input type="checkbox"/> Emp+chd <input type="checkbox"/> Family
MG02	<input type="checkbox"/> Cigna Open Access Plus PPO 90	\$1,238	\$2,476	\$2,228	\$3,714	
MG03	<input type="checkbox"/> Cigna Open Access Plus PPO 80	\$1,061	\$2,122	\$1,910	\$3,183	
MGM1	<input type="checkbox"/> Cigna Open Access Plus MSP PPO 100	\$1,108	\$2,216	\$1,994	\$3,324	
MGM2	<input type="checkbox"/> Cigna Open Access Plus MSP PPO 90	\$990	\$1,980	\$1,782	\$2,970	
MGM3	<input type="checkbox"/> Cigna Open Access Plus MSP PPO 80	\$850	\$1,700	\$1,530	\$2,550	
MHDC	<input type="checkbox"/> Cigna Open Access Plus CDHP-20/HSA	\$833	\$1,666	\$1,499	\$2,499	
MHDE	<input type="checkbox"/> Anthem BCBS CDHP-20/HSA	\$833	\$1,666	\$1,499	\$2,499	
MPP1	<input type="checkbox"/> Anthem BCBS BlueCard PPO 100	\$1,400	\$2,800	\$2,520	\$4,200	
MPP2	<input type="checkbox"/> Anthem BCBS BlueCard PPO 90	\$1,238	\$2,476	\$2,228	\$3,714	
MPP3	<input type="checkbox"/> Anthem BCBS BlueCard PPO 80	\$1,061	\$2,122	\$1,910	\$3,183	
MS10	<input type="checkbox"/> Anthem BCBS BlueCard MSP PPO 90	\$990	\$1,980	\$1,782	\$2,970	
MS11	<input type="checkbox"/> Anthem BCBS BlueCard MSP PPO 80	\$850	\$1,700	\$1,530	\$2,550	
MSG9	<input type="checkbox"/> Anthem BCBS BlueCard MSP PPO 100	\$1,108	\$2,216	\$1,994	\$3,324	
	<input type="checkbox"/> I decline medical coverage					

2025 Election (check one)		<b>DENTAL</b>				DENTAL (check one)
Option Code	Plan Name	Single	Emp+1	Emp+chd	Family	
DCOM	<input type="checkbox"/> Delta Dental Comprehensive	\$67	\$134	\$121	\$201	<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	\$56	\$112	\$101	\$168	
DPRE	<input type="checkbox"/> Delta Dental Premium	\$103	\$206	\$185	\$309	
	<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

**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 \_\_\_\_\_