

Listed below are the health plan choices offered by your group and the associated monthly rates for each, effective 01/01/2026. If you wish to select coverage, please complete the appropriate spaces below and check the box next to your 2026 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 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).

2026 Election (check one) **2026 Health Plan Choices** **MEDICAL (check one)**

Option

Code	Plan Name	Single	Emp+1	Emp+chd	Family
MG01	<input type="checkbox"/> Cigna Open Access Plus PPO 100	\$1,526	\$3,052	\$2,747	\$4,578
MG02	<input type="checkbox"/> Cigna Open Access Plus PPO 90	\$1,337	\$2,674	\$2,407	\$4,011
MG03	<input type="checkbox"/> Cigna Open Access Plus PPO 80	\$1,135	\$2,270	\$2,043	\$3,405
MGM1	<input type="checkbox"/> Cigna Open Access Plus MSP PPO 100	\$1,208	\$2,416	\$2,174	\$3,624
MGM2	<input type="checkbox"/> Cigna Open Access Plus MSP PPO 90	\$1,069	\$2,138	\$1,924	\$3,207
MGM3	<input type="checkbox"/> Cigna Open Access Plus MSP PPO 80	\$910	\$1,820	\$1,638	\$2,730
MHDC	<input type="checkbox"/> Cigna Open Access Plus CDHP-20/HSA	\$891	\$1,782	\$1,604	\$2,673
MHDE	<input type="checkbox"/> Anthem BCBS CDHP-20/HSA	\$891	\$1,782	\$1,604	\$2,673
MPP1	<input type="checkbox"/> Anthem BCBS BlueCard PPO 100	\$1,526	\$3,052	\$2,747	\$4,578
MPP2	<input type="checkbox"/> Anthem BCBS BlueCard PPO 90	\$1,337	\$2,674	\$2,407	\$4,011
MPP3	<input type="checkbox"/> Anthem BCBS BlueCard PPO 80	\$1,135	\$2,270	\$2,043	\$3,405
MS10	<input type="checkbox"/> Anthem BCBS BlueCard MSP PPO 90	\$1,069	\$2,138	\$1,924	\$3,207
MS11	<input type="checkbox"/> Anthem BCBS BlueCard MSP PPO 80	\$910	\$1,820	\$1,638	\$2,730
MSG9	<input type="checkbox"/> Anthem BCBS BlueCard MSP PPO 100	\$1,208	\$2,416	\$2,174	\$3,624
	<input type="checkbox"/> I decline medical coverage				

Single
 Emp+1
 Emp+chd
 Family

Option

Code	Plan Name	Single	Emp+1	Emp+chd	Family
DCOM	<input type="checkbox"/> Delta Dental Comprehensive	\$67	\$134	\$121	\$201
DDBA	<input type="checkbox"/> Delta Dental Basic	\$56	\$112	\$101	\$168
DPRE	<input type="checkbox"/> Delta Dental Premium	\$104	\$208	\$187	\$312
	<input type="checkbox"/> I decline dental coverage				

DENTAL (check one)

Single
 Emp+1
 Emp+chd
 Family

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