

The Episcopal Diocese of California
1055 Taylor St. San Francisco, CA 94108
General phone: 415-673-5015

Direct to Benefits Office: 415-869-7805
Benefits Direct Fax: 415-673-4863
Benefits email: sarahc@diocal.org

Canonically Resident Clergy Benefits Annual Enrollment Form

[Canonically resident clergy can enroll in Diocesan group medical or dental benefits at their own expense.
Submit this form to Diocesan Benefits Coordinator within 30 days of Ordination date]

Cleric Enrollee Information

Effective Date: Jan 1, 2022

Name: _____ Email: _____

SS #: _____ Date of Birth: _____ Ordination Date _____ **circle**: Priest or Deacon

Gender: _____ Marital/Partner Status (**circle one**): Single Married State Registered Domestic Partner

Preferred Mailing Address: _____

City, State, Zip: _____ Home Ph: (____) _____

Mobile Ph: (____) _____ Work Phone: (____) _____

Personal Email: _____ Work Email: _____

Benefit Elections (check the box & circle the level of coverage of your selection)

Monthly Premiums for: Single Dual Family

Medical Plan:

<input type="checkbox"/> Kaiser EPO 80	\$924.55	\$1,664.60	\$2,589.15
<input type="checkbox"/> Anthem BCBS BlueCard PPO 80	\$984.00	\$1,771.20	\$2,755.20
<input type="checkbox"/> Anthem BCBS BlueCard PPO 90	\$1,083.43	\$1,950.58	\$3,034.00
<input type="checkbox"/> Kaiser EPO High	\$1,144.93	\$1,962.88	\$3,206.20

Dental Plan:

<input type="checkbox"/> Cigna Dental/Ortho	\$ 78.93	\$142.48	\$221.40
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Dependent Information (list only those to be added/removed from medical coverage)

Children, up to age 30, may be enrolled in our plans. If you wish to enroll one or more dependents please list them below, use additional page if necessary.

	Names	Date of Birth	Social Security #	Gender	Add Dep:
Partner/Spouse:	_____	_____	_____	M / F	<input type="checkbox"/> Med <input type="checkbox"/> Dental
Child(ren):	_____	_____	_____	M / F	<input type="checkbox"/> Med <input type="checkbox"/> Dental
	_____	_____	_____	M / F	<input type="checkbox"/> Med <input type="checkbox"/> Dental
	_____	_____	_____	M / F	<input type="checkbox"/> Med <input type="checkbox"/> Dental
	_____	_____	_____	M / F	<input type="checkbox"/> Med <input type="checkbox"/> Dental
	_____	_____	_____	M / F	<input type="checkbox"/> Med <input type="checkbox"/> Dental

Sign & Date: _____