

Evangelical Presbyterian Church

Medical Enrollment Form

Please fax this form to EPC Billing Office at (412) 201-2250

Church Name (Employer) _____ City _____ State _____ Zip _____

Employee Information

**To qualify for benefits a person must work at least 30 hours per week*

**Refer to Medical Plan Booklet for Details (www.epc.org/benefits) then go to medical plan*

Last Name _____ First Name _____ MI _____

Street Address _____ Social Security # ____ / ____ / ____

City _____ State _____ Zip _____ Birth Date ____ / ____ / ____
mm dd yyyy Male
Female

Active Pastor Retired Pastor Pastor Out-of-Bounds Pastor W/O Call WO Missionary Other

Transfer from another church Name of Prior Church _____

Day Time Phone (____) _____ E-mail _____

Medical Plan Chosen	Basic	Premium	HDHP	
Type of Coverage	Single	Couple	Family	Employee & Children

Dependent Information

For additional dependents, include employee name along with dependent information on a separate sheet

Spouse

Last Name _____ First Name _____ MI _____

Birth Date ____ / ____ / ____ (mm/dd/yyyy) Social Security # ____ / ____ / ____

Dependents under 26 years of age

Last Name _____ First Name _____ MI _____

Birth Date ____ / ____ / ____ SS# ____ / ____ / ____ Male Female
mm dd yyyy

Last Name _____ First Name _____ MI _____

Birth Date ____ / ____ / ____ SS# ____ / ____ / ____ Male Female
mm dd yyyy

Last Name _____ First Name _____ MI _____

Birth Date ____ / ____ / ____ SS# ____ / ____ / ____ Male Female
mm dd yyyy

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Employee Signature _____ Date ____ / ____ / ____ (mm/dd/yyyy)

Church Officer Signature _____ Date ____ / ____ / ____ (mm/dd/yyyy)

Customer Number from Invoice (Required field) _____

Date of Hire ____ / ____ / ____ (mm/dd/yyyy) Effective Date of Coverage ____ / ____ / ____ (mm/dd/yyyy)