



# CHURCH PENSION GROUP

445 Fifth Avenue  
 New York, NY 10016  
 Active Member Services: 800.480.9967  
 Retiree Member Services: 866.273.4545  
 Fax (both): 212.592.9499  
 www.cpg.org

The Episcopal Church Medical Trust  
 Church Life Insurance Corporation

## Health Statement Medical and Group Life Insurance

A Health Statement, providing evidence of insurability, is required when the person to be insured is applying for late enrollment. Provide all of the information requested, have the employee's signature witnessed, and have the witness sign this form. Return the Health Statement with your Enrollment Form.

**1**

### Information About the Employee

_____				Date	___ / ___ / ___	Coverage	___ / ___ / ___
Title	First Name	M.I.	Last Name	Hired	Mo / Day / Yr	Effective	Mo / Day / Yr
(The Rev., Mr., Mrs., Ms., etc.)							
_____				Birth	___ / ___ / ___	Soc.	- -
				Date	Mo / Day / Yr	Sec. No.	_____

### Residence

\_\_\_\_\_

Street

\_\_\_\_\_

City State Zip

\_\_\_\_\_

Home Phone E-mail

### Mailing Address (if different)

\_\_\_\_\_

Street

\_\_\_\_\_

City State Zip

**2**

### Name of Episcopal Organization

_____			Phone	E-mail	List Bill ID
Name of Episcopal Organization					
_____			City	State	Zip
Street					

**3**

### Information About Those Applying for Insurance

Employee      Birth \_\_\_ / \_\_\_ / \_\_\_      Weight \_\_\_\_\_ lbs.      Height \_\_\_\_ ft. \_\_\_\_ in.  
 Date Mo / Day / Yr

 Dependents

Full Name	Relationship	Soc. Sec. No.	Birth Date (M/D/Y)	Weight (lbs.)	Height (ft./in.)
_____	_____	- -	___ / ___ / ___	_____	_____
_____	_____	- -	___ / ___ / ___	_____	_____
_____	_____	- -	___ / ___ / ___	_____	_____

