

MCSIG CHANGE FORM  **MCSIG**  **EMPLOYER'S COBRA FORM**

*Employee or Employer representative: Use this form to report certain events to MCSIG as required under provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Failure to complete and submit this form in a timely manner may result in a loss of health insurance continuation that are available under COBRA. The notice must be sent back within 10 days after the later of (a) the date of qualifying event, or (b) the date that qualifying beneficiary would lose coverage on account of the qualifying event.

I	EMPLOYEE NAME (must be legal name)									
	Last: _____			First: _____			MI: _____			
	Birth Date: ____/____/____		Social Security ____-____-____			District SCESD				
II	EMPLOYEE ADDRESS									
	Mailing Address Required: _____									
	Street			City			State		Zip	
	Email Address: _____@_____					Phone # (____) _____				
III	DEPENDENT CHANGE Note: You may only add dependents during annual November open enrollment or a special qualifying event									
	Type "Add" or "Remove" in the box provided next to each dependent's name									
<i>Add or Remove</i>	Last Name	First Name	MI	SSN Required	Relationship	Gender (type below)	DOB	MED	DEN	VIS
IV	BENEFIT PLAN CHANGES (Required Documentation on reverse side)									
	Medical	Dental - No Ortho		Vision		Reason for Plan Change			OPT-OUT (EE only)	
	PPO25	Low		Plan C		Term			Medical	
	PPO40	Med				Marriage			Dental	
	PPO60	High				Retirement			Vision	
	PPO SELECT (Complete Disclaimer on reverse side)	Grand				Addition/Loss of Other Coverage			Eff. Date	/ /
						Add Dependents			Proof of other coverage must be attached	
						Loss Coverage				
				KAISER		Change of Employment				
	Trio HMO	Low		Med		High	Loss or Ineligible Dependent			
	COMPLETECARE					Open Enrollment				
V	EMPLOYEE NAME CHANGE Note: Copy of social security card is required									
	Former Last Name _____					Present Last, MI, First _____				
VI	CHANGE OF BENEFICIARY Note: Life insurance is provided with medical plan enrollment only (25K Active / 5K Retiree)									
	Beneficiary Name		Beneficiary Address			Beneficiary Relationship			Percentage = 100%	
COMMENTS										
I hereby request the changes hereon to be made and authorize the applicable change in my contributions.										
Employee Signature X _____						Date Signed _____			20 _____	
Employee Representative X _____						Date Signed _____			20 _____	
EMPLOYER USE ONLY					MCSIG USE ONLY					
Eff. Date January 1, 2025		Group # 5200			Posted _____		Date _____		Initial _____	
FSA: Yes _____ No _____		Sub group # _____								

PPO Select Plan Disclaimer

I understand that by enrolling in the PPO Select plan, my dependents and I do not have out-of-network coverage. I can search for Blue Shield of California in-network providers by selecting PPO Select as the plan option at: [Blue Shield/MCSIG's microsite](#).

Initial _____

I have reviewed this information with my adult dependents covered by my plan and they understand the plan restrictions.

Initial _____

I understand that the PPO Select plan **excludes** Monterey County hospitals and their owned facilities that bill under the Monterey county hospitals Tax Identification number. The excluded hospitals are Community Hospital of the Monterey Peninsula, Natividad Medical Center, and Mee Memorial Hospital. Note: Salinas Valley Health Medical Center is in-network, effective 3/1/24. Note: you and your dependents will be covered in the case of a true emergency (e.g. taken by ambulance, severe and sudden pain, broken bones or referral by a medical provider). All plan design charges will apply. Please note: that the billing submitted by the hospital is what will determine if the visit was a true emergency. If referred to one of the above hospitals by your doctor, urgent care facility, Teladoc, Transcarent or any other medical provider but the hospital bill does not reflect an emergency, call MCSIG Customer Service at (831) 755-8055 to report the referral so that your claim can be reviewed. For a list of in-network hospitals, register and search at: [Blue Shield/MCSIG's microsite](#).

Initial _____

The PPO Select Plan includes Transcarent Surgery Care, a free high quality surgery benefit with more than 100% coverage and no out-of-pocket expenses. Their suite of tools, services and dedicated Care Coordinators are available to help you when considering a planned surgery. Get connected with a Care Coordinator at (855) 586-2744.

Once enrolled and benefits have been activated, obtain further guidance to best manage your healthcare needs, by registering online at webapp.transcarent.ai/activate and connect with a health guide to get concierge-level support on your needs. In addition, MCSIG Customer Service is at your service at (831) 755-8055, M-F 8-5 p.m.

I attest by signing below that I have reviewed the PPO Select Disclaimer within this document. I understand that I am eligible to change plans during Open Enrollment every November for a January 1 effective. I may also change plans if I encounter a qualifying event outside of Open Enrollment (e.g. marriage, divorce, birth of a child). Please refer to your Benefit Booklet for a complete list of qualifying events at: www.mcsig.com (under the Health Plans tab).

Insured Legal Last Name: _____ Legal First Name: _____

Insured Signature: _____ Date: _____

REQUIRED DOCUMENTATION* Attach copies of: Certified Marriage Certificate, Domestic Partner State Registration Certificate (Same sex partners or opposite sex partners), Birth Certificates (for ALL dependent children), Adoption (Adoption Placement Papers), Legal Guardianship (final paperwork showing effective date), Proof of enrollment in other medical coverage (for employee to opt-out of medical plan), MCSIG Disabled Dependent Form.

*Any required documentation that is not included with the enrollment form will delay the enrollment process.

RETURN THIS FORM TO YOUR EMPLOYER BENEFITS DEPARTMENT