

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

municipalities • colleges • schools
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*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 _____						
II	EMPLOYEE ADDRESS								Phone # (____) _____		
	Mailing Address Required: _____										
	Street _____			City _____			State _____		Zip _____		
	Email Address: _____@_____										
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										
	Medical		Dental		Vision		Reason for Plan Change			OPT-OUT (EE only)	
	PPO25		High		Plan B		Term			Medical	
	PPO40		No Ortho				Marriage			Dental	
	PPO60						Retirement			Vision	
	PPO SELECT (Complete Disclaimer on reverse side)						Addition/Loss of Other Coverage			Eff. Date ____ / ____ / ____	
							Add Dependents			Proof of other coverage must be attached	
							Loss Coverage				
							Change of Employment				
	Trio HMO						Loss or Ineligible Dependent				
	COMPLETECARE						Special 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 _____			Group # _____			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: _____