

MCSIG CHANGE FORM

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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 _____									
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									
Add or Remove	Last Name	First Name	MI	SSN Required	Relationship	Gender (type below)	DOB	MED	DEN	VIS
Add										
IV	BENEFIT PLAN CHANGES (Please see reverse side for disclaimers and documentation requirements)									
	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		Grand				Addition/Loss of Other Coverage		Eff. Date	/ /
	Trio HMO		KAISER				Add Dependents		Proof of other coverage must be attached	
	COMPLETECARE		Low	Med	High		Loss Coverage			
							Change of Employment			
							Loss or Ineligible Dependent			
							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 # _____										

See back for required documentation and important notices →

2025 SCESD_MCSIG Change Form Rev. 7/22/25

MY HEALTH PLAN ACKNOWLEDGMENT AND REQUIRED ACTIONS

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: blueshieldca.com Initial _____

PPO Select Plan Disclaimer:

I understand that the PPO Select plan excludes Monterey County hospitals and their owned facilities that bill under the Monterey County hospital's Tax ID #. The excluded hospitals are Community Hospital of the Monterey Peninsula, Natividad Medical Center, and Mee Memorial Hospital. Note: You and your dependents will be covered in the case of a true emergency (e.g., transported by ambulance, severe chest pain, severe wounds, or broken bones). All plan design charges will apply. Please note that the hospital's billing determines whether a visit qualifies as a true emergency. If referred to one of the above hospitals by your doctor, urgent care provider, Transcarent, or any other medical provider, but the 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. Initial _____

PPO Select, PPO25, PPO40, PPO60, PPO250 Disclaimer:

I understand that I am required to contact Transcarent at (855) 586-2744 for all elective surgeries. When I go through Transcarent, eligible surgeries are covered at no cost to me. If I don't use Transcarent for eligible services, I understand that my claim will be denied in full, as required by the plan. I also understand that I'm encouraged to contact Transcarent for cancer care coordination, where I can get personalized guidance and support throughout my treatment. Once I'm enrolled in one of the PPO plans listed above and my benefits are active, I'll register with Transcarent either online at webapp.transcarent.ai/activate or by downloading the Transcarent app from the App Store or Google Play. For any questions, I can call MCSIG Customer Service at (831) 755-8055, M-F: 8 a.m.-5 p.m. Initial _____

Acknowledgment:

By signing below, I confirm that I've reviewed the disclaimers in this document. I understand that I can change plans during Open Enrollment in November for coverage starting January 1. I also understand that I may change plans outside of Open Enrollment if I experience a qualifying life event, such as marriage, divorce, or the birth of a child. To view the full list of qualifying events, refer to your Benefit Booklet at www.mcsig.com under the Health Plans tab.

Insured Legal Last Name: _____ Insured Legal First Name: _____

Insured Signature: _____ Date: _____

NEWBORNS: The member's newborn child is eligible to be enrolled, and the enrollment request must be submitted within 31 days of the date of birth. Coverage will commence on the date of birth. If a request for enrollment is not received within 31 days of the date of birth, the newborn child is not eligible to be enrolled for coverage until the annual open-enrollment period or until the employee experiences a qualifying event. A copy of the birth certificate and a Social Security Number are required within 60 days of the effective 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