MCSIG

Municipalities, Colleges, Schools, Insurance Group

ENROLLMENT FORM

DISTRICT USE	
Group # (4-digit District ID)	**Subgroup #** (3-digit employee class)

I. EMPLOYEE INFORMATION

Social Security Number	First Legal Name	MI	Last Legal Name	Mailing Address	City	State	Zip Code
___ ___							

Date of Birth	Gender (type below)	Marital status: ☐ Single ☐ Married ☐ Domestic Partner	Are you married to a MCSIG covered employee? ☐ Yes ☐ No If Yes, provide Spouse Work Location: _____	Email _____ @ _____	Home Phone (____) _____
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II. MCSIG PLAN SELECTION

NOTE: Employees must enroll in their own plan in order to be enrolled as a dependent of another employee's MCSIG plan

NEW ENROLLMENT	**COVERAGE OPTIONS**	***MEDICAL PLAN OPTIONS***							***DENTAL PLAN OPTIONS***				***VISION PLAN OPTIONS***
EFFECTIVE DATE ____/____/____		PPO $25	PPO $40	PPO $60	PPO SELECT	KAISER PLANS Check one ☐Low ☐Med ☐High	TRIO HMO	COMPLETECARE	Low No Ortho	Medium No Ortho	High No Ortho	Grand No Ortho	Plan C
	Employee Only												
START DATE ____/____/____	Employee + One												
	Employee + Family												

III. DEPENDENT ENROLLMENT INFORMATION

(Please list all dependents to be enrolled (Attach additional sheets if necessary.) Documentation required: Marriage Certificate, Birth Certificate, etc... See reverse

MEDICAL	DENTAL	VISION	**RELATIONSHIP** Type for each	**GENDER** Type for each	**EFFECTIVE DATE**	**LAST NAME**	**FIRST NAME**	**MI**	**SOCIAL SECURITY # REQUIRED**	**Has other health plan?** Enter YES or NO (If yes, see back)	**BIRTH DATE**	**AGE**	**TOTALLY DISABLED?** Enter YES or NO

IV. LIFE INSURANCE BENEFICIARY DESIGNATION*

– To be completed by employee. If more space is needed, please attach separate page. **Life Insurance is provided with Medical Plan enrollment only.*

Beneficiary #1 Name	*Address*	*City*	*State*	*Zip Code*	*Relationship*	*Percentage* %
Beneficiary #2 Name	*Address*	*City*	*State*	*Zip Code*	*Relationship*	*Percentage* %

(complete the reverse side)

PLEASE READ CAREFULLY-SIGNATURE REQUIRED

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions and misstatements.

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required contribution.

NON-PARTICIPATION PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

SETTLEMENT OF DISPUTES: I understand that MCSIG has a Settlement of Disputes process, as described in the Benefits Booklet (available at www.mcsig.com).

AUTHORIZATION: I hereby authorize my physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent of MCSIG any and all records related to medical history, services rendered, or treatment given to anyone enrolled in my health plan for purpose of review, investigation, or analysis of any application or claim. I also authorize MCSIG or its agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer, or insurer any such medical information obtained if such disclosure is necessary if such processing is necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as is necessary to enable MCSIG to process claims.

Summary of Benefits and Coverage (SBC) summarizes important information about any health care option in a standard format and is available on the web at www.mcsig.com. A paper copy of the SBC and Plan Handbook is also available, free of charge, by calling 1(800) 287-1442 (toll-free). The information you are asked to provide on this enrollment form is used only for technical and administration purposes and is not shared with anyone outside of the confines of administering your health care coverage.

ELIGIBILITY: I understand that **new employees must enroll within 31 days of their eligibility date to obtain coverage**. Eligible dependents must be enrolled within 31 days of a qualifying event. If a dependent is no longer eligible for coverage (i.e., divorce, overage child, etc.) I will notify MCSIG of the change within 31 days. Adding ineligible dependents to the MCSIG plans constitutes fraud, and I will be liable to pay back any claims paid for ineligible members.

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.

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

Insured Legal Name: _____ **Employee Signature:X** _____ **Date:** _____

MY HEALTH PLAN ACKNOWLEDGEMENT AND REQUIRED ACTIONS

I understand that by enrolling in the PPO Select plan, my dependents and I do not have out-of-network coverage. For a list of in-network providers or hospitals search at: deltahealthsystems.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 Monte rey 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: _____

PPOSelect, PPO25, PPO40, PPO60 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 fromt he App Store or Google Play. If I have any questions, I can call MCSIG Customer Service at (831) 755 -8055, Mon-Fri: 8 a.m. to 5 p.m.

Initial: _____

OTHER HEALTH PLAN COVERAGE FOR COORDINATION OF BENEFITS

(you or dependents): ☐ None ☐ Yes If yes, complete below.

Policyholder / Relationship	Carrier	Group / Policy #	Effective Date	Individuals Covered (list names)

Note: It is your responsibility to notify MCSIG immediately of any changes to other health coverage. Failure to do so may delay claims processing.

DECLINATION OF COVERAGE - OPT-OUTS ONLY

I acknowledge that I have been provided with, reviewed, and received information regarding insurance coverages available through MCSIG. I hereby decline the coverage(s) indicated below for myself and/or my dependents.

Acknowledgment of Waiver for Myself and/or Dependents

By initialing below, I understand that if I decline coverage at this time, I waive my right to enroll in that coverage until the next Annual Open Enrollment.*

Medical (includes Life Insurance): _____

Dental: _____

Vision: _____

***Must provide proof of other medical coverage (employee only).**

**Active employees are eligible to participate in Annual Open Enrollment. Retirees are not subject to Annual Open Enrollment.*

Employee Signature: _____ Date: _____

Employer Representative/Title: _____ Date: _____

RETURN YOUR COMPLETED FORM TO YOUR EMPLOYER BENEFIT REPRESENTATIVE FOR PROCESSING. PLEASE RETAIN A COPY FOR YOUR RECORDS.