[X] MCSIG CHANGE FORM [ ] 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 INFORMATION (must be legal name)

Last: _____ First: _____ MI: _____

Birth Date: _____/_____/_____ Social Security _____-_____-_____ District **Salinas City ESD**

Mailing Address Required: _____ _____ _____ _____
Street City State Zip

Email Address: _____@_____ Phone # (____) _____

II 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

III BENEFIT PLAN CHANGES

Medical		*Dental - No Ortho*		*Vision*		*Reason for Plan Change*		*OPT-OUT (EE only)*	
PPO25		Low		Plan C		Termination/Resignation		Medical	
PPO40		Med				Date of Last Day Worked		Dental	
PPO60		High				Marriage		Vision	
PPO SELECT		Grand				Retirement		Eff. Date	/ /
KAISER		Low		Med		High		Addition/Loss of Other Coverage		Proof of other coverage must be attached
TRIO HMO								Add Dependents		
COMPLETECARE								Change of Employment		
								Ineligible Dependent		
								Open Enrollment	X	

IV EMPLOYEE NAME CHANGE Note: Copy of social security card is required

Former Last Name _____ Present Last, MI, First _____

V 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

Eff. Date January 1, 2027 Group # 5200

FSA: Yes _____ No _____ Sub group #_____

MCSIG USE ONLY

Posted _____ Date _____ Initial _____

See reverse side for required documentation and important notices if Sections II and/or III are completed.

MY HEALTH PLAN ACKNOWLEDGMENT AND REQUIRED ACTIONS

PPO Select Plan No Out-of-Network Coverage 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: 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 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 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.

Acknowledgment: Initial _____

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.

RETURN THIS FORM TO YOUR EMPLOYER BENEFITS DEPARTMENT

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