MCSIG
municipalities • colleges • schools
insurance group

Catilize Health®

MERP ENROLLMENT FORM

EMPLOYER INFORMATION	
Employer Name: MCSIG	
Please mail, email or fax completed form to:	
Your Health & Welfare Representative	Email: memberservices@catilizehealth.com Telephone: 877-872-4232 Toll Free Fax: 877-599-3724

I am enrolling in the MERP for (please check one):

☐ Self Only

☐ Self & Children

☐ Children Only

☐ Spouse/Domestic Partner Only

☐ Self & Spouse/Domestic Partner

☐ Self & Family

☐ Spouse/Domestic Partner & Children

PARTICIPANT INFORMATION		
Name:	D.O.B:	Hire Date:
Social Security #:	Gender: ☐ M ☐ F	Eligibility Date:
Home Street Address:		
City:	State:	Zipcode:
Home Phone:	Work Phone:	Cell Phone:
Email Address:		

SPOUSE/DOMESTIC PARTNER INFORMATION		
Name:	D.O.B:	Gender: ☐ M ☐ F
Social Security #:	Spouse/Domestic Partner Employer:	

DEPENDENT INFORMATION (attach a seperate sheet if additional space is needed)		
Name:	D.O.B:	Gender: ☐ M ☐ F
Social Security #:		
Name:	D.O.B:	Gender: ☐ M ☐ F
Social Security #:		
Name:	D.O.B:	Gender: ☐ M ☐ F
Social Security #:		
Name:	D.O.B:	Gender: ☐ M ☐ F
Social Security #:		
Name:	D.O.B:	Gender: ☐ M ☐ F
Social Security #:		
Name:	D.O.B:	Gender: ☐ M ☐ F
Social Security #:		

PARTICIPANT AUTHORIZATION

* If the other coverage is a HDHP and your spouse/domestic partner is not enrolled in the CompleteCare, your spouse/domestic partner may contribute to the HSA and use the HSA funds. The HSA funds CANNOT be used for medical expenses for members enrolled in the CompleteCare. All members may use the HSA funds for dental and/or vision as long as those expenses are not covered by the spouse/domestic partner. Also, if your primary health coverage is through Medicare, Tricare VA health care, or Medicaid, you are not eligible for the CompleteCare.

I hereby authorize my employer to enroll me into the employer sponsored CompleteCare. I agree to comply with the terms and conditions of the plan. You may be prosecuted for fraud for knowingly using health insurance benefits for which you are not eligible. It is YOUR responsibility to know when you or a family member is no longer eligible for CompleteCare benefits.

Employee Signature:	Date:

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