☐ MCSIG CHANGE FORM | MCSIG municipalities • colleges • schools insurance group | ☐ 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**

Medical		*Dental*		*Vision*		*Reason for Plan Change*		*OPT-OUT (EE only)*	
PPO25		High w/Ortho		Plan C		Term		Medical	
PPO30						Marriage		Dental	
PPO40						Retirement		Vision	
PPO50		*Life Insurance Opt-In*				Addition/Loss of Other Coverage		Eff. Date	/ /
PPO60		EAP/Life Insurance (Selection only for active employees opting out of medical)				Add Dependents		Proof of other coverage must be attached	
PPO SELECT (Complete Disclaimer on reverse side)		KAISER				Loss Coverage			
						Change of Employment			
Trio HMO		Low		Med		High		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

Eff. Date _____ Group # _____

FSA: Yes _____ No _____ Sub group #_____

MCSIG USE ONLY

Posted _____ Date _____ Initial _____

RETURN THIS FORM TO YOUR EMPLOYER BENEFITS DEPARTMENT

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: _____