Print

☐ MCSIG CHANGE FORM — MCSIG — EMPLOYER'S COBRA FORM ☐

Monterey County Schools Insurance Group

Employee or District 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). Failture to complete and submit this form in a timely manner may result in a loss of health insurance continuation rights 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: ______________________

Social Security No.: ______________ District: Hartnell (3000) Classification: ______

II

Mailing Address (reqd.) ______________________
STREET CITY STATE ZIP

Telephone ( ) ______________________ New Address? ☐ Yes ☐ No
AREA CODE TELEPHONE NUMBER

III

Dependent Change **NOTE :** You may only add dependents during the annual November open enrollment (unless you have a qualifying event, marriage, birth, etc)

To ADD or REMOVE Covered Individuals, Check one and fill out completely (LAST NAME / FIRST / INITIAL)	Relationship	Gender	Date of Birth (MO. DAY YR.)	Med	Dental	Vision
☐ ADD ______ ☐ REMOVE SS# Required ___ ___ ___ – ___ ___ – ___ ___ ___ ___		☐ M ☐ F		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
☐ ADD ______ ☐ REMOVE SS# Required ___ ___ ___ – ___ ___ – ___ ___ ___ ___		☐ M ☐ F		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
☐ ADD ______ ☐ REMOVE SS# Required ___ ___ ___ – ___ ___ – ___ ___ ___ ___		☐ M ☐ F		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
☐ ADD ______ ☐ REMOVE SS# Required ___ ___ ___ – ___ ___ – ___ ___ ___ ___		☐ M ☐ F		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

IV

Medical Plan Change ☐ PPO 20 ☐ PPO 25 ☐ PPO 30 ☐ PPO 35 ☐ PPO 40 ☐ PPO 50 ☐ PPO 60 ☐ EPO SoCal

☐ **OPT-OUT OF MEDICAL COVERAGE** ______ *Proof of other coverage must be attached.
*EFFECTIVE DATE

Dental Plan Change ☐ Low ■ Medium ☐ High **and** ■ With Ortho ☐ Without Ortho

Vision Plan Change ☐ Plan A ■ Plan B ☐ Plan C

Reason for Plan Change: (Check Box)
- ☐ Annual Re-enrollment
- ☐ Marriage
- ☐ Termination
- ☐ Divorce (Face Page Needed)
- ☐ Change of Employment Status/ Addition/Reduction of Hours
- ☐ Addition of Dependents
- ☐ Loss of Dependents/Child Ceasing to be Dependent
- ☐ Addition/Loss of Other Coverage
- ☐ Other ______

V

Employee Name Change: ______________ ______________
Former Last Name — Present Last Name — MI — First Name

(copy of social security card or driver's license required)

VI

Change of Beneficiary (for life insurance active members only):

Name of Beneficiary ______________ Relationship ______

Address ______________________
STREET CITY STATE ZIP

Comments

I hereby request the changes hereon to be made and authorize the applicable change in my contributions.

Date Signed: ______________ 20 ____

Employee's Signature: **X** ______________________

____
Employee Representative

____
Date

FOR DISTRICT USE ONLY	DISTRICT	MCSIG
	Eff. Date ______ Group # 3000 Sub Group # ______ FSA: ☐ YES ☐ NO	Posted ______ Date ______ Initial ______

Return this form to your district office Benefits Department

DECLINATION OF COVERAGE FORM

I was provided with and am signing acknowledgment of review and receipt of coverage and enrollment information for the insurance coverages provided through Monterey County Schools Insurance Group. I hereby decline the indicated coverages offered for the following persons:

SELF		**SSN**

Check applicable coverages:

☐ Medical * ☐ Dental ☐ Vision

*MUST provide proof of other other medical coverage

SPOUSE		**SSN**

Check applicable coverages:

☐ Medical ☐ Dental ☐ Vision

Check reason: ☐ covered under another plan ☐ not covered, but do not choose to enroll at this time

CHILD		**SSN**
CHILD		**SSN**
CHILD		**SSN**

Check applicable coverages:

☐ Medical ☐ Dental ☐ Vision

Check reason: ☐ covered under another plan ☐ not covered, but do not choose to enroll at this time

I, the undersigned, understand that if I decline medical coverage (includes declining Life Insurance) at this time, I waive my right to re-enroll in the medical plan until the next annual open enrollment, after a full one-year wait. _____ Initial

I, the undersigned, understand that if I decline dental coverage at this time, I waive my right to enroll in the dental plan for a minimum of 24 months. _____ Initial

I, the undersigned, understand that if I decline vision coverage at this time, I waive my right to enroll in the vision plan for a minimum of 24 months. _____ Initial

EXCEPT: If the reason for declining coverage was due to the fact the person was covered under another plan and has lost or will lose such coverage due to non-voluntary termination of employment or the plan, non-voluntary change in employment status, the person may enroll in the plans if:

The person enrolls within 31 days after termination of such coverage.
Verification of termination of such coverage is provided to Monterey County Schools Insurance Group (MCSIG).

_____ _____
Employee Name (print or type) Employee Signature

_____ _____
Employer Employer Representative &Title

_____
Date signed