☑ 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 Name:

Last: ______ First: ______ MI: ____ Birth Date: ______

Social Security: ____ – ____ – ____ District: Hartnell College (3000) Classification: Click to Select

II

New Address? Yes ☐ No ☐

Mailing Address is Required: ______

Street City State Zip

Telephone (_____) ________ Email Address: ______

III

Dependent Change NOTE: You may only add dependents during 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 / MI)	Relationship	Gender	Date of Birth MONTH/DAY/YEAR	Medical	Dental	Vision
☐ ADD ☐ REMOVE SS# Required ___ ___ ___ – ___ ___ – ___ ___ ___ ___	Click to Select	☐ M ☐ F		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
☐ ADD ☐ REMOVE SS# Required ___ ___ ___ – ___ ___ – ___ ___ ___ ___	Click to Select	☐ M ☐ F		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
☐ ADD ☐ REMOVE SS# Required ___ ___ ___ – ___ ___ – ___ ___ ___ ___	Click to Select	☐ M ☐ F		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
☐ ADD ☐ REMOVE SS# Required ___ ___ ___ – ___ ___ – ___ ___ ___ ___	Click to Select	☐ M ☐ F		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

IV

Medical Plan Change:

☐PPO25 ☐ PPO30 ☐PPO40
☐PPO50 ☐PPO60
☐PPO Select ☐CompleteCare

Opt-out Of Coverage:

☐Medical ☐Dental ☐Vision

*Effective Date ______ / 01 /202___

*Proof of other coverage **must** be attached.

Dental Plan Change:

☐ **Medium**

☑ **With Ortho**

Vision Plan Change:

☐ **Plan B**

****Reason for Plan Change:** (Check Box):

☐ Termination ☐ Marriage ☐ Divorce
☐ Addition of Dependents ☐ Retirement
☐ Addition/Loss of Other Coverage
☐ Change of Employment Status/Addition/Reduction of Hours
☐ Loss of Dependents/Child Ceasing to be Dependent
☐ **Special Open Enrollment** **(O.E. closes Nov 29 for Jan Changes)**
☐Other: ______

***Note relevant documents needed to support changes** (e.g.) County marriage certif; Divorce decree; County birth/adoption certif; Verif of other new or lost coverage.*

V

Employee Name Change: Former Last Name ______ Present Last Name, MI, First Name ______ (copy of Social Security card required)

VI

Change of Beneficiary (life insurance is provided with Medical Plan enrollment only)
Life Insurance declining benefit is $25K for Actives / $5K for Retirees

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's Signature: **X** ______ Date Signed: ______ 20 _____

______
Employer Representative

______
Date

FOR DISTRICT USE ONLY	ESC: ____ **EMPLOYER** PR: ____ Eff. Date / 01 /202__ Group # 3000 FSA: ☐ YES ☐ NO Sub Group # Select	**MCSIG** Posted ______ Date ______ Initial ______

MCSIG

Return this form to your employer Benefits Department MCSIG Change Form Rev 10/6/20

Docs: MC / DP / DD / BC / Verif / CCare docs / Other: Pend: ____ Final: ____