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

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: ______

Complete this page if declining any coverage for yourself or eligible dependent(s).

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 MCSIG. 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. _____ Initial

I, the undersigned, understand that if I decline dental coverage at this time, I waive my right to enroll in the dental plan until the next open enrollment. _____ Initial

I, the undersigned, understand that if I decline vision coverage at this time, I waive my right to enroll in the vision plan until the next open enrollment. _____ 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 MCSIG.

_____ _____
Employee Name (print or type) Employee Signature

Hartnell Community College District _____
Employer Employer Representative &Title

_____
Date signed