

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: _____ Classification: _____								
II New Address? Mailing Address is Required: Yes ☐ No ☐ _____ 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 _____ - _____ - _____				☐ 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: ☐ PPO25 ☐ PPO30 ☐ PPO40 ☐ PPO50 ☐ PPO60 ☐ PPO Select ☐ CompleteCare ☐ Kaiser: Low Med High <u>Opt-out Of Coverage:</u> ☐ Medical ☐ Dental ☐ Vision *Effective Date _____ *Proof of other coverage <u>must</u> be attached.			Dental Plan Change: ☐ Low ☐ Medium ☐ High ☐ Grand AND ☐ With Ortho ☐ Without Ortho Vision Plan Change: ☐ Plan A ☐ Plan B ☐ Plan C		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 ☐ Other: _____			
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	
	Eff. Date _____		Posted _____	
	Group # _____		Date _____ Initial _____	
	FSA: ☐ YES ☐ NO Sub Group # _____			



MCSIG

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

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

Employer

Employer Representative & Title

Date signed