☒ MCSIG CHANGE FORM ☐ EMPLOYER'S COBRA FORM

Reset 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 Community College (3000) Classification: Select an Item:

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 ___ – ___ – ____	Select an Item:	☐ M ☐ F		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
☐ ADD ______ ☐ REMOVE SS# Required ___ – ___ – ____	Select an Item:	☐ M ☐ F		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
☐ ADD ______ ☐ REMOVE SS# Required ___ – ___ – ____	Select an Item:	☐ M ☐ F		☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
☐ ADD ______ ☐ REMOVE SS# Required ___ – ___ – ____	Select an Item:	☐ 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 ______
*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
☐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	Axs EMPLOYER	PR/Esc MCSIG
	Eff. Date / 01 / 2021	Posted ______
	Group # 3000	Date ______ Initial ______
	FSA: ☐ YES ☐ NO Sub Group #_	

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

HCCD/HR/lnr Rev 10/30/20