MCSIG

Hartnell College
ENROLLMENT FORM

DISTRICT USE	
Group # (4-digit District ID)	**Subgroup #** (3-digit employee class)

I. EMPLOYEE INFORMATION

Social Security Number	First Legal Name	MI	Last Legal Name	Mailing Address	City	State	Zip Code
___ ___							

Date of Birth	Gender (type below)	Marital status: ☐ Single ☐ Married ☐ Domestic Partner	Are you married to a MCSIG covered employee? ☐ Yes ☐ No If Yes, provide Spouse WorkLocation: _____	Email _____ @ _____	Home Phone (_____) _____
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II. MCSIG PLAN SELECTION

NOTE: Employees must enroll in their own plan in order to be enrolled as a dependent of another employee's MCSIG plan

NEW ENROLLMENT	**COVERAGE OPTIONS**	***MEDICAL PLAN OPTIONS***									***DENTAL PLAN OPTIONS***				***VISION PLAN OPTIONS***		
EFFECTIVE DATE		PPO $25					PPO SELECT	Trio HMO	COMPLETECARE			Medium w/Ortho				Plan B	
____/____/____	Employee Only																
DATE OF HIRE	Employee + One																
____/____/____	Employee + Family																

III. DEPENDENT ENROLLMENT INFORMATION

(Please list all dependents to be enrolled (Attach additional sheets if necessary.) Documentation required: Marriage License, Birth Certificate, etc... See reverse

MEDICAL	DENTAL	VISION	RELATIONSHIP Type for each	GENDER Type for each	EFFECTIVE DATE	LAST NAME	FIRST NAME	MI	SOCIAL SECURITY # REQUIRED	Has other health plan? Enter YES or NO	BIRTH DATE	AGE	TOTALLY DISABLED? Enter YES or NO

IV. LIFE INSURANCE BENEFICIARY DESIGNATION*

– To be completed by employee. If more space is needed, please attach separate page. **Life Insurance is provided with Medical Plan enrollment only.*

Beneficiary #1 Name	*Address*	*City*	*State*	*Zip Code*	*Relationship*	*Percentage* %
Beneficiary #2 Name	*Address*	*City*	*State*	*Zip Code*	*Relationship*	*Percentage* %

(complete the reverse side)

PLEASE READ CAREFULLY-SIGNATURE REQUIRED

I attest by signing below that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions and misstatements.

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required contribution.

NON-PARTICIPATION PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

ELIGIBILITY: I understand that eligible dependents must be enrolled within 31 days of a qualifying event. If a dependent is no longer eligible for coverage (i.e., divorce, overage child, etc.) I will notify MCSIG of the change within 31 days. Adding ineligible dependents to the MCSIG plans constitutes fraud, and I will be liable to pay back any claims paid for ineligible members.

EFFECTIVE DATE: The effective date of coverage is subject to the eligibility guidelines of the employer and MCSIG.

AUTHORIZATION: I hereby authorize my physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent of MCSIG any and all records related to medical history, services rendered, or treatment given to anyone enrolled in my health plan for purpose of review, investigation, or analysis of any application or claim. I also authorize MCSIG or its agents, designees or representatives to disclose to a hospital or health care service plan, self- insurer or insurer any such medical information obtained if such disclosure is necessary if such processing is necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as is necessary to enable MCSIG to process claims.

Summary of Benefits and Coverage (SBC) summarizes important information about any health care option in a standard format and is available on the web at www.MCSIG.com. A paper copy of the SBC and Plan Handbook is also available, free of charge, by calling 1(800) 287-1442 (toll free). The information you are asked to provide on this enrollment form is used only for technical and administration purposes and is not shared with anyone outside of the confines of administering your health care coverage.

Employee Signature: X_____ **Date:** _____

REQUIRED DOCUMENTATION* Attach copies of: Certified Marriage Certificate, Domestic Partner State Registration Certificate (Same sex partners or opposite sex partners), Birth Certificates (for ALL dependent children), Adoption (Adoption Placement Papers), Legal Guardianship (final paperwork showing effective date), Proof of enrollment in other medical coverage (for employee to opt-out of medical plan), MCSIG Disabled Dependent Form**.**
***Any required documentation that is not included with the enrollment form will delay the enrollment process.**

PPO Select Plan Disclaimer

I understand that by enrolling in the PPO Select plan, my dependents and I do **not** have out-of-network coverage. I can search for BlueShield of California in-network providers at: Blue Shield/MCSIG's microsite. Initial _____

I have reviewed this information with my adult dependents covered by my plan and they understand the plan restrictions. Initial _____

I understand that the PPO Select plan **excludes** Monterey County hospitals and their owned facilities that bill under the Monterey County hospitals Tax ID #. The excluded hospitals are Community Hospital of the Monterey Peninsula (CHOMP), Salinas Valley Health (SVH), Natividad Medical Center (NMC) and Mee Memorial Hospital. Note: you and your dependents will be covered in the case of a true emergency (e.g. taken by ambulance, severe wounds, broken bones severe chest pain, or referral by a medical provider). All plan design charges will apply. Please note: that the billing submitted by the hospital is what will determine if the visit was a true emergency. If referred to one of the above hospitals by your doctor, urgent care facility, Teladoc, Transcarent or any other medical provider but the hospital bill does not reflect an emergency, call MCSIG Customer Service at (831) 755-8055 to report the referral so that your claim can be reviewed. For a list of in-network hospitals, register and search at: Blue Shield/MCSIG's microsite. Initial_____

The PPO Select Plan includes Transcarent Surgery Care, a free high-quality surgery benefit with more than 100% coverage and no out-of-pocket expenses. Their suite of tools, services and dedicated Care Coordinators are available to help you when considering a planned surgery. Get connected with a Care Coordinator at (855) 586-2744. Once enrolled and benefits have been activated, obtain further guidance to best manage your healthcare needs, by registering online at webapp.transcarent.ai/activate and connect with a health guide to get concierge-level support on your needs. In addition, MCSIG Customer Service is at your service at (831) 755-8055, M-F 8-5 p.m.

I attest by signing below that I have reviewed the PPO Select Disclaimer within this document. I understand that I am eligible to change plans during Open Enrollment every November for a January 1 effective. I may also change plans if I encounter a qualifying event outside of Open Enrollment (e.g. marriage, divorce, birth of a child). Please refer to your Benefit Booklet for a complete list of qualifying events at: www.mcsig.com (under the Health Plans tab).

Insured Legal Name: _____ **Insured Signature:** _____ **Date:** _____

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 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 annual 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 annual open enrollment*

_____Initial

*ACTIVE EMPLOYEES are eligible to participate in the Annual Open Enrollment.

*RETIREES are not subject to the Annual Open Enrollment.

Employee Name	Employer
Employee Signature	Employer Representative & Title
Date	Date

RETURN YOUR COMPLETED FORM TO YOUR EMPLOYER BENEFIT REPRESENTATIVE FOR PROCESSING. PLEASE RETAIN A COPY FOR YOUR RECORDS.