



Spouse Primary Coverage Form

(Includes domestic partners)

PLAN YEAR 2011

Who must complete this form? Any member electing to cover their spouse in a MCSIG self-funded plan. Continuing members will be required to complete/return this form annually if your spouse is going to continue as a dependent on your MCSIG self-funded plan.

MCSIG participant name (printed): _____ SSN# (last 4 digits) _____

MCSIG participant district: _____

Please check the one box that qualifies your spouse as eligible for coverage as a dependent on MCSIG:

- 1. My spouse is unemployed, self-employed or retired; or is a MCSIG participant (employee of a MCSIG member district). District Name: _____
- 2. My spouse is employed and my spouse's employer does NOT offer medical coverage for my spouse.
- 3. My spouse is employed, my spouse's employer DOES offer medical insurance for my spouse and:
 - my spouse does not meet their employer's medical insurance eligibility requirements; or
 - my spouse's employer pays less than 75% of the employee-only medical premium; or
 - my spouse's employer pays at least 75% of the employee-only medical premium and my spouse is currently enrolled in their employer's medical insurance

AFFIDAVIT: I understand that my spouse must meet one of the eligibility requirements above to qualify for enrollment as my dependent in MCSIG. I certify the above information to be true and correct.

Member's Signature: _____

If box 2 or any box under 3 above is checked, have the spouse sign below and take this form to their employer to complete the spouse employer verification of coverage (below) before returning this form to MCSIG.

I authorize the release of the health care plan coverage information requested below and authorize its use in applying for dependent coverage in MCSIG.

Spouse name (printed): _____

Spouse Signature: _____ Date: _____

SPOUSE EMPLOYER VERIFICATION OF COVERAGE

The person named above (spouse) is employed by us and:

- we do not offer employee medical insurance coverage.

We offer employee medical insurance coverage and:

- the person named above does not meet our medical insurance eligibility requirements; or
- we pay less than 75% of the employee-only medical premium; or
- we pay at least 75% of the employee-only medical premium and the person named above is/is not (circle one) enrolled in our medical insurance coverage. Plan name: _____

Authorized Employer Contact Signature: _____

Printed Name and Title: _____

Benefits Department Phone Number: _____

Employer Name: _____

Please return this form to: MCSIG, 76 Stephanie Drive, Salinas, CA 93901, 831-755-0161