☐ 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: PGUSD Classification: CERTIFICATED

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 ___ – ___ – ___		☐ 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:

☐PPO20 ☐PPO25 ☐PPO30 ☐PPO35
☐PPO40 ☐PPO50 ☐PPO60
☐EPOSoCal ☐CompleteCare
☐Kaiser: ☐Low $40 ☐Mid $20 ☐High $20

Opt-out Of Coverage:

☐Medical ☐Dental ☐Vision

*Effective Date ______

*Proof of other coverage must 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

VI

Change of Beneficiary (for life insurance active members only): **(copy of social security card required**

Name of Beneficiary: ______ Relationship ______

Address: ______

STREET CITY STATE ZIP

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 ______ Group # 5000 FSA: ☐ YES ☐ NO Sub Group # 120	Posted ______ Date ______ Initial ______

MCSIG **Return this form to your employer Benefits Department** MCSIG Change Form Rev 11/14/17