

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
 Telephone (____) _____ Street _____ City _____ State _____ Zip _____
 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	Relationship	Gender	Date of Birth	Medical	Dental	Vision
LAST NAME FIRST MI			MONTH/DAY/YEAR			
<input type="checkbox"/> ADD _____ <input type="checkbox"/> REMOVE SS# Required _____ - _____ - _____		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> ADD _____ <input type="checkbox"/> REMOVE SS# Required _____ - _____ - _____		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> ADD _____ <input type="checkbox"/> REMOVE SS# Required _____ - _____ - _____		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> ADD _____ <input type="checkbox"/> REMOVE SS# Required _____ - _____ - _____		<input type="checkbox"/> M <input type="checkbox"/> F		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> 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 _____	EMPLOYER Eff. Date _____ Group # _____ FSA: <input type="checkbox"/> YES <input type="checkbox"/> NO Sub Group # _____	MCSIG Posted _____ Date _____ Initial _____
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