

CompleteCare Enrollment Form



MCSIG
municipalities • colleges • schools
insurance group

EMPLOYER INFORMATION

Employer Name: MUNICIPALITIES, COLLEGES, SCHOOLS INSURANCE GROUP (MCSIG)

Please send completed form and mail, fax or email to: LISA MARTINEZ, BENEFITS & ELIGIBILITY SPECIALIST

MCSIG

76 Stephanie Drive
Salinas, CA 93901

FAX: 831-755-0172

EMAIL: LMartinez@mcsig.com

I am enrolling in the MCSIG CompleteCare for: Self Only Self & Child(ren) Child(ren) Only
 Spouse Only Self & Spouse Self & Family Spouse & Child(ren)

PARTICIPANT INFORMATION

Employee Name:	Birthdate:	Hire Date:
Social Security No:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Date Eligible for MCSIG CompleteCare:
Home Street Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:
Email Address:		

SPOUSE INFORMATION

Spouse's Name:	Birthdate:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Social Security No:	Spouse's:	
Spouse's Pay Period for Health Premium Contribution: <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Weekly <i>Please indicate if the medical deduction DOES NOT come out of every paycheck. Some may only be once a month or the first two pays of the month.</i>		
Spouse's Health Premium Contribution per Pay Period: \$_____ ** INCLUDE DOCUMENTATION, I.E. PAYSTUB OR BENEFIT STATEMENT		
Are Spouse's Health Premium Contribution / Deductions: <input type="checkbox"/> Before Taxes (OR) <input type="checkbox"/> After Taxes		

* Contribution per pay period should include the cost for Medical only; Dental & Vision are not covered under this plan.

If submitting a spouse's paystub, please circle the contribution/deduction amount on the paystub.

* DO NOT BLACKOUT THE PAY PERIOD.

** Send a copy of your spouse's paystub that shows the NEW contribution/deduction as of the MCSIG CompleteCare effective date listed above. This amount should reflect the cost of adding you and/or any dependents to the spouse's plan.

*** If your spouse's plan has a High Deductible with a Health Savings Account (HSA), you are not eligible to participate in the MCSIG CompleteCare, unless the employer allows your spouse to drop the HSA portion of the plan. Written documentation required. Also, if your primary health coverage is through Medicare, Tricare (Retiree only) or Medicaid, you are not eligible for the MCSIG CompleteCare.**

DEPENDENT INFORMATION: (Attach a separate sheet if additional space is needed for additional dependents)

Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security No:		
Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security No:		
Name:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security No:		

PARTICIPANT AUTHORIZATION

I hereby authorize my employer to enroll me into the employer sponsored MCSIG CompleteCare. I agree to comply with the terms and conditions of the plan. I understand that if the health premium contributions are deducted on an After-Tax Basis, this will result in all premium reimbursements being income tax free. However, if the contributions are on a Pre-Tax Basis, the premium reimbursements will be fully taxable. In either case, the deductible, co-pay and co-insurance reimbursements will remain tax free. **I further understand that if any current contributions are made to a Health Savings Account (HSA) by my spouse or his/her Employer, I am not eligible to participate in the MCSIG CompleteCare offered through my employer.**

Employee Signature:

Date: