☐ # MCSIG CHANGE FORM ☐ EMPLOYER'S COBRA FORM

SUHSD - SVFT

*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? 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

IV

Medical Plan Change:

☐ PPO$25 ☐ PPO$30

☐ PPO$40 ☐ PPO$50

☐ PPO Select

Opt-out of Coverage:

☐ Medical ☐ Dental ☐ Vision

Effective Date: ☐

Proof of other coverage must be attached

Other Plan Change: ☐ EAP ☐ Life Ins

Kaiser Plan Change:

☐ Medium

CompleteCare Change:

☐ Reimbursement Plan

Dental Plan Change:

☐ Medium w/Ortho

☐ High w/Ortho

Vision Plan Change:

☐ A

Reason for Plan Change (Check Box):

☐ Termination ☐ Marriage ☐ Divorce ☐ Death

☐ Addition of Dependents ☐ Overage Dependent

☐ Addition/Loss of Other Coverage ☐ Retirement

☐ Employment Change 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 ____________ (copy of Social Security card required)

VI

Change of Beneficiary (life insurance is provided with Medical Plan enrollment only)

Life Insurance declining benefit is $25K for Actives / $5K for Retirees

Beneficiary Name	Beneficiary Address	Beneficiary Relationship	Percentage = 100

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 # ____________	Posted ____________ Date ________ Initial ________

MCSIG **Return this form to your employer Benefits Department** MCSIG Change Form Rev 10/9/20