

# 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 _____	<b>EMPLOYER</b> Eff. Date _____ Group # _____ FSA: <input type="checkbox"/> YES <input type="checkbox"/> NO Sub Group # _____	<b>MCSIG</b> Posted _____ Date _____ Initial _____
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