MCSIG Enrollment Form

DISTRICT USE						
Group # (4-digit District ID)				**Subgroup #** (3-digit employee class)		
5	0	0	0	1	2	0

I. EMPLOYEE INFORMATION

Social Security Number	*First Name*	*MI*	*Last Name*	*Mailing Address*	*City*	*State*	*Zip Code*

Date of Birth	*Gender*	*Marital status*	*Are you married to a MCSIG covered employee?* ❑ Yes ❑ No	*Email*	*Home Phone*
	❑ M ❑ F	❑ Single ❑ Married	*If Yes, provide Spouse Work Location:* ____________		

II. MCSIG PLAN SELECTION

❑ New Enrollment		M = MEDICAL PLAN OPTIONS									D = DENTAL PLAN OPTIONS			V = VISION PLAN OPTIONS			
Effective Date	Coverage Options	PPO $20	PPO $25	PPO $30	PPO $35	PPO $40	PPO $50	PPO $60	EPO So Cal				High ☒ No Ortho ❑ With Ortho				C
Date of Hire	Employee Only	❑	❑	❑	❑	❑	❑	❑	❑				❑				❑
	Employee + One	❑	❑	❑	❑	❑	❑	❑	❑				❑				❑
	Employee + Family	❑	❑	❑	❑	❑	❑	❑	❑				❑				❑

III. DEPENDENT ENROLLMENT INFORMATION (Please list all dependents to be enrolled (Attach additional sheets if necessary.) Documentation required: Marriage License, Birth Certificate, etc... See reverse

M	D	V	Relation	Effective Date	Last Name	First Name	MI	Social Security Number (Required)	Has other health plan?	Birth Date	Age	Totally Disabled?
			☐ *Spouse* ☐ *Domestic Partner* ☐ *M* ☐ *F*						☐Y ☐N ☐Y ☐N ☐Y ☐N			☐Y ☐N ☐Y ☐N ☐Y ☐N
			☐ *Son* ☐ *Daughter*						☐Y ☐N ☐Y ☐N			☐Y ☐N ☐Y ☐N
			☐ *Son* ☐ *Daughter*						☐Y ☐N ☐Y ☐N			☐Y ☐N ☐Y ☐N
			☐ *Son* ☐ *Daughter*						☐Y ☐N ☐Y ☐N			☐Y ☐N ☐Y ☐N
			☐ *Son* ☐ *Daughter*						☐Y ☐N ☐Y ☐N			☐Y ☐N ☐Y ☐N
			☐ *Son* ☐ *Daughter*						☐Y ☐N ☐Y ☐N			☐Y ☐N ☐Y ☐N
			☐ *Son* ☐ *Daughter*						☐Y ☐N ☐Y ☐N			☐Y ☐N ☐Y ☐N

IV. LIFE INSURANCE BENEFICIARY DESIGNATION* – To be completed by employee. If more space is needed, please attach separate page. **Life Insurance is provided with Medical Plan enrollment only.*

Beneficiary #1 Name	*Address*	*City*	*State*	*Zip Code*	*Relationship*	*Percentage*
Beneficiary #2 Name	*Address*	*City*	*State*	*Zip Code*	*Relationship*	*Percentage*

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(complete the reverse side)

PLEASE READ CAREFULLY—SIGNATURE REQUIRED

I attest by signing bellow that I have reviewed the information provided on this application and to the best of my knowledge and belief, it is true and accurate with no omissions and misstatements.

DEDUCTION AUTHORIZATION: If applicable, I authorize my employer to deduct from my wages the required contribution.

NON-PARTICIPATION PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

ELIGIBILITY: I understand that eligible dependents must be enrolled within 30 days of a qualifying event. If a dependent is no longer eligible for coverage (i.e. divorce, overage child. Etc.) I will notify MCSIG of the change within 30 days.

EFFECTIVE DATE: The effective date of coverage is subject to the eligibility guidelines of the employer and MCSIG.

REQUIREMENT FOR BINDING ARBITRATION:
I UNDERSTAND THAT MCSIG REQUIRES BINDING ARBITRATION TO SETTLE ALL DISPUTES, AS DESCRIBED IN THE MEDICAL PLAN HANDBOOK. (Available @ www.MCSIG.com)

AUTHORIZATION:
I hereby authorize my physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent of MCSIG any and all records related to medical history, services rendered, or treatment given to anyone enrolled in my health plan for purpose of review, investigation, or analysis of any application or claim.

I also authorize MCSIG or its agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer or insurer any such medical information obtained if such disclosure is necessary if such processing is necessary to allow the processing of any claim.

This authorization shall become effective immediately and shall remain in effect as is necessary to enable MCSIG to process claims.

Summary of Benefits and Coverage (SBC) summarizes important information about any health care option in a standard format and is available on the web at www.MCSIG.com. A paper copy of the SBC and Plan Handbook is also available, free of charge, by calling 1(800) 287-1442 (toll free).

The information you are asked to provide on this enrollment form is used only for technical and administration purposes and is not shared with anyone outside of the confines of administering your health care coverage.

Employee Signature: X _____Date: _____

Documentation that is required*. Please attach copies of:

- Certified Marriage Certificate
- Domestic Partner State Registration Certificate (Same sex partners or over 62 opposite sex partners)
- Birth Certificates (for ALL dependent children)
- Adoption (Adoption Placement Papers)
- Legal Guardianship (final paperwork showing effective date)
- Proof of enrollment in other medical coverage, for employee to opt-out of medical plan
- MCSIG Disabled Dependent Form

***Any required documentation that is not included with the enrollment form will delay the enrollment process.**

DECLINATION OF COVERAGE FORM

I was provided with and am signing acknowledgment of review and receipt of coverage and enrollment information for the insurance coverages provided through MCSIG. I hereby decline the indicated coverages offered for the following persons:

SELF		**SSN**

Check applicable coverages:

☐ Medical * ☐ Dental ☐ Vision

*MUST provide proof of other other medical coverage

SPOUSE		**SSN**

Check applicable coverages:

☐ Medical ☐ Dental ☐ Vision

Check reason: ☐ covered under another plan ❑ not covered, but do not choose to enroll at this time

CHILD		**SSN**
CHILD		**SSN**
CHILD		**SSN**

Check applicable coverages:

☐ Medical ☐ Dental ☐ Vision

Check reason: ☐ covered under another plan ☐ not covered, but do not choose to enroll at this time

I, the undersigned, understand that if I decline medical coverage (includes declining Life Insurance) at this time, I waive my right to re-enroll in the medical plan until the next annual open enrollment. _____ Initial

I, the undersigned, understand that if I decline dental coverage at this time, I waive my right to enroll in the dental plan until the next annual open enrollment. _____ Initial

I, the undersigned, understand that if I decline vision coverage at this time, I waive my right to enroll in the vision plan until the next annual open enrollment. _____ Initial

EXCEPT: If the reason for declining coverage was due to a HIPAA Qualifying Event; such as if the person was covered under another plan and has lost or will lose such coverage due to non-voluntary termination of employment or the plan, non-voluntary change in employment status, the person may enroll in the plans if:

The person enrolls within 31 days after termination of such coverage.
Verification of termination of such coverage is provided to MCSIG.

_____ Employee Name (print or type)

_____ Employee Signature

PGUSD Employer

MONICA VALERO Employer Representative &Title

_____ Date signed

RETURN YOUR COMPLETED FORM TO YOUR EMPLOYER BENEFIT REPRESENTATIVE FOR PROCESSING. PLEASE RETAIN A COPY FOR YOUR RECORDS.