ENROLLMENT FORM

MCSIG

DISTRICT USE				
Group # (4-digit District ID)				Subgroup # (3-digit employee class)
3	0	0	0	Click to Select

I. EMPLOYEE INFORMATION

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

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

II. MCSIG PLAN SELECTION

■ New Enrollment — ("Enter" to Select Plan AND Level of Coverage)

	Coverage Options	MEDICAL PLAN OPTIONS: PPO $25	PPO $30	PPO $40	PPO $50	PPO $60	PPO SELECT	MED OPT-OUT ** ALSO SEE PAGE 2 DECLINATION	COMPLETECARE ** ALSO SEE PAGE 2 DECLINATION	DENTAL PLAN OPTIONS: Medium ☐ No Ortho ■ With Ortho	VISION PLAN OPTIONS: Plan B
Effective Date ______ / 01 /202__											
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

MED	DEN	VIS	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
☐	☐	☐	☐ Son ☐ Daughter						☐Y ☐N			☐Y ☐N
☐	☐	☐	☐ Son ☐ Daughter						☐Y ☐N			☐Y ☐N
☐	☐	☐	☐ Son ☐ Daughter						☐Y ☐N			☐Y ☐N
☐	☐	☐	☐ Son ☐ Daughter						☐Y ☐N			☐Y ☐N
☐	☐	☐	☐ Son ☐ Daughter						☐Y ☐N			☐Y ☐N
☐	☐	☐	☐ Son ☐ Daughter						☐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

Rev 10/28/15

(complete the reverse side)

Note: Complete the declination section on pg 2 if beneficiary is a spouse who is not enrolled in MCSIG coverage.

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. Adding ineligible dependents to the MCSIG plans constitutes fraud, and I will be liable to pay back any claims paid for ineligible members.

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 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

*ACTIVE EMPLOYEES are eligible to participate in the Annual Open Enrollment.

*RETIREES are not subject to the Annual Open Enrollment.

Employee Name _____ Employee Signature _____

Employer _____ Employer Representative & Title _____

Date Signed _____

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