CompleteCare Enrollment Form

EMPLOYER INFORMATION

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

Please send completed form and mail or fax information to:

J & K Consultants, Inc.
2605 Nicholson Road, Suite 1140
Sewickley, PA 15143

TOLL FREE FAX: 877-599-3724
TELEPHONE: 877-872-4232
EMAIL: rachelt@jandkcons.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: ◉M ◉F	Date Eligible for MCSIG CompleteCare: 01/01/2018
Home Street Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:
Email Address:		

SPOUSE INFORMATION

Spouse Name:	Birthdate:	Gender: ◯M ◯F
Social Security No:	Spouse's Employer:	

Spouse's Pay Period for Health Premium Contribution: ◉Monthly ◉Semi-Monthly ◉Bi-Weekly ◉Weekly

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.

Spouse's Health Premium Contribution per Pay Period: $_____ **** INCLUDE DOCUMENTATION, I.E. PAYSTUB OR BENEFIT STATEMENT**

Are Spouse's Health Premium Contribution / Deductions: ◉ Before Taxes **(OR)** ◉ After Taxes

* Contribution per pay period should include the cost for Medical only; Dental & Vision are not covered under this plan.
If submitting a spousal paystub, please circle the contribution/deduction amount on the submitted 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 or Tricare, 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: ◉ Male ◉Female
Social Security No:		
Name:	Date of Birth:	Gender: ◉ Male ◉ Female
Social Security No:		
Name:	Date of Birth:	Gender: ◉ Male ◉Female

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 though my employer.**

Employee Signature: **Date:**