MCSIG CompleteCare Enrollment Form

Catilize Health®

EMPLOYER INFORMATION

Employer Name: MCSIG

Please mail, e-mail or fax completed form to:

MCSIG
76 Stephanie Drive
Salinas, CA 93901

TOLL FREE FAX: 831-755-0172
EMAIL: Lsierra@mcsig.com

I am enrolling in CompleteCare for (Please check one): ☐Self Only ☐Self & Child(ren) ☐Child(ren) Only ☐Self & Family ☐Spouse/domestic partner Only ☐Self & Spouse/domestic partner ☐Spouse/domestic partner & Child(ren)

PARTICIPANT INFORMATION

Employee Name:	Birthdate:	Hire Date:
Social Security No:	Gender: ☐M ☐F	Date Eligible for CompleteCare:
Home Street Address:		
City:	State:	Zip Code:
Home Phone:	Work Phone:	Cell Phone:
Email Address:		

SPOUSE/DOMESTIC PARTNER INFORMATION

Spouse/domestic partner Name:	Birthdate:	Gender: ☐M ☐F
Social Security No:	Spouse/domestic partner's Employer:	

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

Are Spouse/domestic partner'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 spouse/domestic partner's paystub, please circle the contribution/deduction amount on the paystub.
* DO NOT BLACKOUT THE PAY PERIOD.
** Send a copy of your spouse/domestic partner's paystub that shows the NEW contribution/deduction as of CompleteCare effective date listed above. This amount should reflect the cost of adding you and/or any dependents to the spouse/domestic partner's plan.
*** If the other coverage is a HDHP and your spouse/domestic partner is not enrolled in CompleteCare, your spouse/domestic partner may contribute to the HSA and use the HSA funds. The HSA funds CANNOT be used for medical expenses for members enrolled in CompleteCare. All members may use the HSA funds for dental and/or vision as long as those expenses are not covered by CompleteCare. Also, if your primary health coverage is through Medicare, Tricare or Medicaid, you are not eligible for 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
Social Security No:		

PARTICIPANT AUTHORIZATION

I hereby authorize my employer to enroll me into the employer sponsored CompleteCare. I agree to comply with the terms and conditions of the plan. You may be prosecuted for fraud for knowingly using health insurance benefits for which you are not eligible. It is YOUR responsibility to know when you or a family member is no longer eligible for CompleteCare benefits. 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/domestic partner or his/her Employer, I am *not eligible* to participate in CompleteCare offered through my employer.**

Employee Signature: **Date:**