CompleteCare Enrollment Form

EMPLOYER INFORMATION

Employer Name: MCSIG

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

Lisa Sierra – Benefits & Eligibility Specialist
76 Stephanie Drive
Salinas, CA 93901

Email: lsierra@mcsig.com
Fax: 831-755-0172

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

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:		
Name:	Date of Birth:	Gender: ☐Male ☐Female
Social Security No:		
Name:	Date of Birth:	Gender: ☐Male ☐Female
Social Security No:		

PARTICIPANT AUTHORIZATION

* 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, VA health care, or Medicaid, you are not eligible for CompleteCare.

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.

Employee Signature: **Date:**