Missouri Consolidated Health Care Plan

Foster Parent Enrollment

Level B Foster Parents

Submit this form
Fax: 866-346-8785
Mail: PO Box 104355
Jefferson City, MO 65110-4355

ST ENR

Revised 10/2021

Section 1: Subscriber Information

Please print carefully.

Name (Last, First, MI): ☐ New Name

MCHCP ID: -

OR

Social Security Number: - -

Address: ☐ New Address

City:

State:

Zip Code:

Date of Birth (MM/DD/YYYY): / /

Email Address:

County Where You Live:

Primary Phone: ☐Home ☐Work ☐Cell
( ) -

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed

Date of Marriage (MM/DD/YYYY): / /

Secondary Phone: ☐Home ☐Work ☐Cell
( ) -

Section 2: Enroll & Select Coverage Levels

Medical

Anthem
☐ PPO 1250
☐ PPO 750
☐ HSA Plan *

☐ TRICARE Supplement

☐ S ☐ S/S ☐ S/C ☐ S/F

Dental

☐ MetLife Dental Plan

☐ S ☐ S/S ☐ S/C ☐ S/F

Vision

☐ NVA - Premium Vision Plan
☐ NVA - Basic Vision Plan

☐ S ☐ S/S ☐ S/C ☐ S/F

Coverage Levels: *S - Subscriber Only* *S/S - Subscriber & Spouse* *S/C - Subscriber & Children* *S/F - Subscriber & Family*

* HSA Plan requires HSA Acceptance Form

Section 3: Dependents to be Enrolled, Changed, or Canceled

Action: *E - Enroll C - Change D - Cancel* **Relation**: *S - Spouse C: Child O: Other (Stepchild, Grandchild, etc)* **Coverage**: *M - Medical D - Dental V - Vision*

If adding a spouse or child, no coverage is provided until proof of eligibility is received. See www.mchcp.org for details. Use additional forms for more space.

Action	Social Security Number:	Name (Last, First, MI):	Date of Birth (MM/DD/YYYY):	Relation:	Gender:	Coverage:
☐E ☐C ☐D	- -		/ /	☐S ☐C ☐O	☐M ☐F	☐M ☐D ☐V
☐E ☐C ☐D	- -		/ /	☐S ☐C ☐O	☐M ☐F	☐M ☐D ☐V
☐E ☐C ☐D	- -		/ /	☐S ☐C ☐O	☐M ☐F	☐M ☐D ☐V
☐E ☐C ☐D	- -		/ /	☐S ☐C ☐O	☐M ☐F	☐M ☐D ☐V
☐E ☐C ☐D	- -		/ /	☐S ☐C ☐O	☐M ☐F	☐M ☐D ☐V
☐E ☐C ☐D	- -		/ /	☐S ☐C ☐O	☐M ☐F	☐M ☐D ☐V

Section 4: Spouse Information

If your spouse is eligible for MCHCP insurance coverage as a Level B Foster Parent, please complete the following information. This helps to ensure you only have to meet one medical plan family deductible and out-of-pocket maximum. Each subscriber will have access to all medical information of the family unit.

Spouse's Name (Last, First, MI):

Spouse's Employer:

Spouse's SSN: - -

Spouse's Date of Birth: / /

Section 5: Employer-Sponsored Health Insurance Coverage Attestation and Subscriber Authorization

I attest that I am not eligible for employer-sponsored health insurance coverage through my employer or my spouse's employer. If I become eligible for employer-sponsored health insurance coverage I will notify MCHCP by phone, fax, or mail immediately. MCHCP will cancel my coverage on the last day of the month in which I request cancellation or the last day of the month in which my other employer-sponsored coverage begins. I also hereby authorize the appropriate providers to release any documentation necessary to process claims/benefits for myself or my dependent(s). I authorize my chosen plan(s) to provide MCHCP the information necessary to validate benefits and payment of claims to which I am entitled under the MCHCP plan.

Signature:

Date (MM/DD/YYYY): / /