



Missouri Consolidated Health Care Plan
 573-751-0771 · 800-487-0771 · www.mchcp.org
 832 Weathered Rock Court, Jefferson City, MO 65101



2017 Open Enrollment Worksheet

State Members

Submit this form:

Online: Upload through myMCHCP
Fax: 866-346-8785
Mail: Must be postmarked by Oct. 31, 2016
 PO Box 104355, Jefferson City, MO 65110-4355

MCHCP Use Only

ST OEWS

Section 1 – Subscriber Information

Name (Last, First, Middle Initial): New Name **MCHCPid** (Provide **either** MCHCPid or Social Security Number)

Address: New Address or **Social Security Number:**

City: _____ **State:** _____ **ZIP Code:** _____ **Date of Birth** (MM/DD/YYYY):

_____ / _____ / _____

County Where You Live: _____ **Marital Status:** Single Married Widowed **Primary Phone Number:** Home Work Cell

_____ (_____) _____ - _____

Preferred Email: _____ **Secondary Phone Number:** Home Work Cell

_____ (_____) _____ - _____

Section 2 – 2017 Plan Election(s) and Coverage Levels (Effective January 1, 2017)

Enroll in a Medical Plan	Enroll in a Dental Plan	Medical	Dental	Vision
<input type="checkbox"/> UMR PPO 300	<input type="checkbox"/> Delta Dental—Dental Plan	<input type="checkbox"/> Subscriber Only	<input type="checkbox"/> Subscriber Only	<input type="checkbox"/> Subscriber Only
<input type="checkbox"/> UMR PPO 600	Enroll in a Vision Plan	<input type="checkbox"/> Subscriber/Spouse	<input type="checkbox"/> Subscriber/Spouse	<input type="checkbox"/> Subscriber/Spouse
<small>Online Only</small> <input type="checkbox"/> UMR HSA Plan	<input type="checkbox"/> NVA—Premium Vision Plan	<input type="checkbox"/> Subscriber/Child(ren)	<input type="checkbox"/> Subscriber/Child(ren)	<input type="checkbox"/> Subscriber/Child(ren)
<input type="checkbox"/> Aetna PPO 300*	<input type="checkbox"/> NVA—Basic Vision Plan	<input type="checkbox"/> Subscriber/Family	<input type="checkbox"/> Subscriber/Family	<input type="checkbox"/> Subscriber/Family
<input type="checkbox"/> Aetna PPO 600*	*You may enroll in Aetna plans only if you live in the Southwest or South Central Missouri Regions.	Medical premiums increase based on each additional child up to five. Refer to the Open Enrollment packet or log in to myMCHCP for details.		
<small>Online Only</small> <input type="checkbox"/> Aetna HSA Plan*	**Administered by Selman & Company			
<input type="checkbox"/> TRICARE Supplement**				

Cancel Medical, Dental and/or Vision Coverage

Cancel Medical Coverage Cancel Dental Coverage Cancel Vision Coverage

Section 3 – Spouse and Dependent Information

Action – E: Continue **D:** Cancel **Relationship – S:** Spouse **C:** Child **O:** Other (Stepchild, Grandchild, etc.) **Coverage – M:** Medical **D:** Dental **V:** Vision

If proof of eligibility has been previously provided for the dependent, mark the box in the **POE** column.

Action (Circle)	Social Security Number	Name (Last, First, Middle Initial)	Date of Birth (MM/DD/YYYY)	Relationship (Circle)	Gender (Circle)	Coverage (Circle)	POE
E D	____-____-____	_____	____/____/____	S C O	M F	M D V	<input type="checkbox"/>
E D	____-____-____	_____	____/____/____	S C O	M F	M D V	<input type="checkbox"/>
E D	____-____-____	_____	____/____/____	S C O	M F	M D V	<input type="checkbox"/>
E D	____-____-____	_____	____/____/____	S C O	M F	M D V	<input type="checkbox"/>

If adding a spouse or child, no coverage is provided until proof of eligibility is received. Refer to www.mchcp.org for details. If more space is needed, please use additional forms.

Section 4 – Married State Employee Roll-Up Option

If your spouse is also eligible for MCHCP medical coverage and either of you enroll children for medical coverage, complete the information below to ensure your family is subject to one combined yearly family deductible and out-of-pocket maximum. **In order to finalize this process, your eligible spouse must provide the same information when they enroll.** Each spouse must enroll in the same plan through the same carrier.

Spouse's Name (Last, First, Middle Initial): _____ **Spouse's Employer:** _____ **Spouse's Social Security Number:** _____

Section 5 – Subscriber Authorization

I hereby make the above designation(s) and authorize the deductions necessary to pay for the coverage selected. If my paycheck is not sufficient to cover the cost, I understand I will be direct billed. 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 received and payment of claims to which I am entitled under the MCHCP plan.

Signature: _____ **Date** (MM/DD/YYYY): _____