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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

Level B Foster Parents

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 OEW

Section 1 – Subscriber Information

Name (Last, First, Middle Initial): ❑ New Name

_____

Address: ❑ New Address

_____

City: _____ **State**: _____ **ZIP Code**: _____

County Where You Live: _____

Preferred Email: _____

Marital Status: ❑ Single ❑ Married ❑ Widowed

MCHCPid (Provide **either** MCHCPid or Social Security Number)

__ __ __ __ __ __ – __ __ __ __ __ __

or **Social Security Number**:

__ __ __ – __ __ – __ __ __ __

Date of Birth (MM/DD/YYYY):

__ __/__ __/__ __ __ __

Primary Phone Number: ❑ Home ❑ Work ❑ Cell

(__ __ __) __ __ __ – __ __ __ __

Secondary Phone Number: ❑ Home ❑ Work ❑ Cell

(__ __ __) __ __ __ – __ __ __ __

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

Enroll in Medical Coverage	Enroll in Dental Coverage	Medical	Dental	Vision
❑ UMR PPO 300	❑ Delta Dental—Dental Plan	❑ Subscriber Only	❑ Subscriber Only	❑ Subscriber Only
❑ UMR PPO 600	**Enroll in Vision Coverage**	❑ Subscriber/Spouse	❑ Subscriber/Spouse	❑ Subscriber/Spouse
Online Only UMR HSA Plan	❑ NVA—Premium Vision Plan	❑ Subscriber/Child(ren)	❑ Subscriber/Child(ren)	❑ Subscriber/Child(ren)
❑ Aetna PPO 300*	❑ NVA—Basic Vision Plan	❑ Subscriber/Family	❑ Subscriber/Family	❑ Subscriber/Family
❑ Aetna PPO 600*				
Online Only Aetna HSA Plan*				

*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 my MCHCP for details.

Cancel Medical, Dental and/or Vision Coverage

❑ Cancel Medical Coverage ❑ Cancel Dental Coverage ❑ Cancel Vision Coverage

Section 3 – Spouse & 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	❑
E D	__ __ __ – __ __ – __ __ __ __		__ __/__ __/__ __ __ __	S C O	M F	M D V	❑
E D	__ __ __ – __ __ – __ __ __ __		__ __/__ __/__ __ __ __	S C O	M F	M D V	❑
E D	__ __ __ – __ __ – __ __ __ __		__ __/__ __/__ __ __ __	S C O	M F	M D V	❑

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 Level B Foster Parent Roll-Up Option

If your spouse is also a Level B Foster Parent and 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 Social Security Number: __ __ __ – __ __ – __ __ __ __

Section 5 – 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 received and payment of claims to which I am entitled under the MCHCP plan.

Signature: _____

Date (MM/DD/YYYY): __ __/__ __/__ __ __ __

Revised: 08/2016