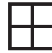
Missouri Consolidated Health Care Plan
573-751-0771 · 800-487-0771 · www.mchcp.org
832 Weathered Rock Court, Jefferson City, MO 65101



2017 Open Enrollment Worksheet

State Retirees

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

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)

Continue Medical coverage
- ❑ UMR PPO 300
- ❑ UMR PPO 600
- Online Only UMR HSA Plan
- ❑ Aetna PPO 300*
- ❑ Aetna PPO 600*
- Online Only Aetna HSA Plan*
- ❑ TRICARE Supplement**

Continue Prescription coverage
- ❑ Medicare Prescription Drug Only Plan

Continue Dental coverage
- ❑ Delta Dental—Dental Plan

Continue Vision coverage
- ❑ NVA—Premium Vision Plan
- ❑ NVA—Basic Vision Plan

Medical	Dental	Vision
❑ Subscriber Only	❑ Subscriber Only	❑ Subscriber Only
❑ Subscriber/Spouse	❑ Subscriber/Spouse	❑ Subscriber/Spouse
❑ Subscriber/Child(ren)	❑ Subscriber/Child(ren)	❑ Subscriber/Child(ren)
❑ Subscriber/Family	❑ Subscriber/Family	❑ Subscriber/Family

Medical premiums increase based on each additional child up to five. Refer to the Open Enrollment packet or log in to myMCHCP for details.

*You may enroll in Aetna plans **only** if you live in the Southwest or South Central Missouri regions.

**Administered by Selman & Company

All medical plan options include prescription drug coverage.
The Medicare Prescription Drug Only Plan does not provide medical coverage.

Cancel Medical, Dental and/or Vision Coverage
If you cancel, you are not eligible to enroll in MCHCP benefits in the future.
❑ 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

Action (Circle)	Social Security Number	Name (Last, First, Middle Initial)	Date of Birth (MM/DD/YYYY)	Relationship (Circle)	Gender (Circle)	Coverage (Circle)
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
E D	___ ___ ___–___ ___–___ ___ ___ ___		___ ___/___ ___/___ ___ ___ ___	S C O	M F	M D V

Section 4 – Subscriber Authorization

I hereby make the above designation(s) and authorize the deductions necessary to pay for the coverage selected. If my retirement check 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):
___ ___ / ___ ___ / ___ ___ ___ ___

Revised: 08/2016