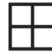
Missouri Consolidated Health Care Plan
573-751-0771 · 800-487-0771 · www.mchcp.org
832 Weathered Rock Court, Jefferson City, MO 65101



Enroll/Change/Cancel

State Members

Submit this form:
- **Online:** Upload through myMCHCP
- **Fax:** 866-346-8785
- **Mail:** PO Box 104355
  Jefferson City, MO 65110-4355

MCHCP Use Only

ST ENR

Please print clearly

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): ___ ___/___ ___/___ ___ ___ ___

Email: ______________________________

County Where You Live: ______________

Primary Phone Number: ❑ Home ❑ Work ❑ Cell

(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

Gender: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Widowed

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

Secondary Phone Number: ❑ Home ❑ Work ❑ Cell

(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

Section 2 – Add, Cancel, Drop Dependent or Transfer Coverage

❑ **Add Coverage:** Due to life event or loss of coverage (If adding yourself or spouse, you may complete Tobacco Attestation)

❑ **Cancel Coverage:**
- ❑ Subscriber *or* ❑ Dependent
- ❑ Medical ❑ Dental ❑ Vision

Reason: ______________________________

❑ **Drop Dependent:** Give reason and date of occurrence
- ❑ Divorce (date): __ __/__ __/__ __ __ __
- ❑ Death (date): __ __/__ __/__ __ __ __
- ❑ Other Coverage: ______________________________
- ❑ Other: ______________________________

Retiree Only:
- ❑ Transfer to my own MCHCP coverage
- ❑ Transfer to my spouse's MCHCP coverage

Spouse's Name (Last, First, Middle Initial): ______________________________

Spouse's Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Section 3 – Plan Continuation, Enrollment and Coverage Levels

Enroll in a Medical Plan	Enroll in a Dental Plan	Medical	Dental	Vision
❑ UMR PPO 300 ❑ UMR HSA Plan*	❑ Delta Dental—Dental Plan	❑ Subscriber Only	❑ Subscriber Only	❑ Subscriber Only
❑ UMR PPO 600	**Enroll in a Vision Plan**	❑ Subscriber/Spouse	❑ Subscriber/Spouse	❑ Subscriber/Spouse
❑ Aetna** 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				
❑ TRICARE Supplement				
❑ Medicare Prescription Drug Only Plan				

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

Medical premiums increase based on each additional child up to five. Refer to the Benefit Guide packet or www.mchcp.org for details.

*If enrolling in the HSA Plan, the HSA Acceptance form is also required.
You may enroll in Aetna plans **only if you live in the Southwest or South Central Regions.

Section 4 – Dependents to be Enrolled, Changed or Cancelled

Action – **E:** Enroll **C:** Change **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 C D	__ __ __–__ __–__ __ __ __	______________	__ __/__ __/__ __ __ __	S C O	M F	M D V	❑
E C 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 5 – Spouse Information

If your spouse is an active employee and **eligible for insurance coverage through MCHCP**, please complete the following information. This helps to ensure you only have to meet one medical plan family deductible and out-of-pocket maximum. MCHCP reserves the right to request proof of eligibility be provided at any time upon request.

Spouse's Name (Last, First, Middle Initial): ______________

Spouse's Employer: ______________

Spouse's Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Spouse's Date of Birth: __ __/__ __/__ __ __ __

Section 6 – Subscriber Authorization

I hereby make the above designation(s) and authorize the deduction necessary to pay for the coverage elected. 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 to provide MCHCP the information necessary to validate benefits received and payment of claims to which I am entitled under the MCHCP plan.

Coverage Effective Date (MM/DD/YYYY): ___ ___/___ ___/___ ___ ___ ___

Signature: ______________________________

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

Revised: 09/2016