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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

Retiree Enrollment

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 RET

Please print clearly

Section 1 – Subscriber Information

Are you or any dependents covered by Medicare? ❑ Yes (Attach copies of Medicare cards) ❑ No

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

Address: ❑ New Address

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

Email:

County Where You Live:

Gender: ❑ Male ❑ Female

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 – Continue, Cancel, Add, or Transfer Coverage

❑ **Continue Coverage**
- ❑ Medical
- ❑ Dental
- ❑ Vision

❑ **Cancel Coverage**
- ❑ Medical
- ❑ Dental
- ❑ Vision

❑ **Add Coverage**
(Attach proof of prior coverage)
- ❑ Medical
- ❑ Dental
- ❑ Vision

❑ **Transfer to my spouse's MCHCP coverage** (Spouse should submit an Enroll/Change/Cancel form to enroll you)

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
- ❑ UMR PPO 300 ❑ UMR HSA Plan*
- ❑ UMR PPO 600
- ❑ Aetna** HSA Plan*
- ❑ Aetna ** PPO 300
- ❑ Aetna** PPO 600
- ❑ TRICARE Supplement
- ❑ Medicare Prescription Drug Only Plan

Enroll in a Dental Plan
- ❑ Delta Dental—Dental Plan

Enroll in a Vision Plan
- ❑ NVA—Premium Vision Plan
- ❑ NVA—Basic Vision Plan

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

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 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 Covered at Retirement

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 – Cafeteria Plan Information and Member Authorization

I have been informed of the benefits and cost of each plan as well as the provisions and restrictions with respect to procedures and changes in my election(s). I hereby make the above designation(s) and authorize the appropriate providers to release any documentation necessary to process claims/benefits for myself or my dependent(s). I authorize my chosen health plan to provide MCHCP the information necessary to validate benefits received and payment of claims to which I am entitled under the MCHCP plan. I acknowledge my first month's premium will be divided between my last two paychecks. If not sufficient, I will be billed for the balance. I also understand that if my MOSERS benefit is sufficient, subsequent monthly retiree premiums will be deducted from my retirement benefit. If not, I will be billed monthly for the full premium amount. I also understand I have the following payment options.

❑ **My premiums are not collected pre-tax through the Cafeteria Plan, and I understand my first month's premium will be divided between my last two paychecks.**

My premiums are collected pre-tax through the Cafeteria Plan:

❑ but I **do not** want to prepay retiree premiums. I understand that my first month's retiree premium will be divided between my last two paychecks.

❑ and I **would like** to prepay retiree premiums through the Cafeteria Plan. I understand my first month's premium will be divided between my last two paychecks. This form must be received at least 31 days prior to your retirement date if you are prepaying retiree premiums through the Cafeteria Plan. The additional amount to be prepaid is **$**__ __ __ __ . __ __ and I'd like this amount to be:

❑ Divided between my last two paychecks ❑ Taken out of my lump-sum vacation payment *(Consult Human Resources for funds available)* ❑ A combination of both options

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

Signature of Subscriber:

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

Revised: 09/2016