



Missouri Consolidated Health Care Plan

Retiree Enrollment

Highway Patrol, MoDOT, & Conservation
Dental & Vision Only

Submit this form

Online: Upload through myMCHCP

Fax: 866-346-8785

Mail: PO Box 104355

Jefferson City, MO 65110-4355

ST RET

Revised 10/2021

Section 1: Subscriber Information

Please print carefully.

Name (Last, First, MI): New Name

Address: New Address

City: State: Zip Code: County Where You Live:

Email Address:

Gender:

Male Female

MCHCP ID: _____

OR _____

Social Security Number: _____

Date of Birth (MM/DD/YYYY): _____

Primary Phone: Home Work Cell

() - _____

Secondary Phone: Home Work Cell

() - _____

Section 2: Continue, Cancel, Add, or Transfer Coverage

Continue Coverage:

Dental

Vision

Cancel Coverage:

Dental

Vision

Add Coverage:

(Attach proof of prior coverage.)

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, MI): _____

Spouse's Social Security Number: _____

Section 3: Enroll & Select Coverage Levels

Dental

MetLife Dental Plan

Vision

NVA - Premium Vision Plan

NVA - Basic Vision Plan

S S/S S/C S/F

S S/S S/C S/F

Coverage Levels: S - Subscriber Only S/S - Subscriber & Spouse S/C - Subscriber & Children S/F - Subscriber & Family

Section 4: Dependents to be Enrolled, Changed, or Canceled

Action: E - Enroll C - Change D - Cancel Relation: S - Spouse C - Child O - Other (Stepchild, Grandchild, etc) Coverage: D - Dental V - Vision

If adding a spouse or child, no coverage is provided until proof of eligibility is received. See www.mchcp.org for details. Use additional forms for more space.

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

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 the 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 deducted from my last paycheck. If not sufficient, I will be billed for the balance. I also understand that if my benefit is sufficient, subsequent monthly retirement 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 taken from my last paycheck.

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 taken from my last paycheck.

and I would like to prepay retiree premiums through the cafeteria plan. I understand that my first month's retiree premium will be taken from my last paycheck. 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: _____

Date (MM/DD/YYYY): _____