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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

Survivor 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 SVR

Please print clearly

Section 1 – Survivor Information

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

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

Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Address: ❑ New Address

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

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

Email:

Primary Phone Number: ❑ Home ❑ Work ❑ Cell
(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

County Where You Live:

Gender: ❑ Male ❑ Female

Secondary Phone Number: ❑ Home ❑ Work ❑ Cell
(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

Section 2 – Deceased Subscriber Information

Name (Last, First, Middle Initial):

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

Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Section 3 – Continue or Add Coverage

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

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

Section 4 – Plan Selections 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
❑ Survivor Only
❑ Survivor & Child(ren)
❑ Child(ren) Only

Dental
❑ Survivor Only
❑ Survivor & Child(ren)
❑ Child(ren) Only

Vision
❑ Survivor Only
❑ Survivor & Child(ren)
❑ Child(ren) Only

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 5 – Dependents to be Covered

Action – **E:** Enroll **C:** Continue **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	___ ___ ___ – ___ ___ – ___ ___ ___ ___		___ ___/___ ___/___ ___ ___ ___	S C O	M F	M D V	❑
E C	___ ___ ___ – ___ ___ – ___ ___ ___ ___		___ ___/___ ___/___ ___ ___ ___	S C O	M F	M D V	❑
E C	___ ___ ___ – ___ ___ – ___ ___ ___ ___		___ ___/___ ___/___ ___ ___ ___	S C O	M F	M D V	❑

If adding a 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 6 – Survivor Authorization

❑ I have attached a personal check in the amount of $___ ___ ___ ___ . ___ ___ to pay for my first month's premium.

❑ I wish to be direct billed for my premiums.

❑ Please deduct my premiums from my survivor benefit check.

I hereby certify the above information is true and correct, and authorize the deduction necessary to pay for the coverage elected (if applicable).

Signature:

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

Revised: 11/2016