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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

Terminated Vested 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 VES

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

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:

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

County Where You Live:

Gender: ❑ Male ❑ Female

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 Selection(s) 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
❑ Dental Plan—Delta Dental

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

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

I hereby request enrollment in MCHCP for myself and eligible qualified dependents listed on this form and agree to pay the premium as required. I understand that full payment (the amount specified in the letter) must be submitted with this form or within 45 days of MCHCP's receipt of this form. I also acknowledge that I will be billed for the premium each month and that failure to pay future billing will result in termination of coverage.

Signature:

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

Revised: 09/2016