






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



Submit this form:
 **Online:** Upload through myMCHCP
 **Fax:** 800-834-5181
 **Mail:** PO Box 104355
 Jefferson City, MO 65110-4355

MCHCP Use Only

PE NSER

Notice of Special Enrollment Rights
 Public Entity Members
 (IRS Reg. 549801-6T(c))

Please print clearly

Section 1 – Subscriber Information

Name (Last, First, Middle Initial): _____ **Social Security Number:** _____-_____-_____

Section 2 – Notice to Subscriber

If you are declining enrollment with MCHCP for yourself or your dependents because of other health insurance coverage, you may be able to enroll yourself or your dependents in this plan in the future, provided that you request enrollment within 60 days after your other coverage ends.

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself and your dependents, provided that you request enrollment within 31 days of the event.

I have read and understand the above notification. I understand that if I decline plan coverage, I can only obtain coverage during MCHCP’s Open Enrollment period or because of the events listed above.

I am declining health care coverage under MCHCP due to the following reason(s):

Section 3 – Subscriber Authorization

Signature: _____  **Date** (MM/DD/YYYY): ____/____/_____