Print Form Reset Form

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

# Notice of Special Enrollment Rights

State Members
(IRS Reg. 549801-6T(c))

**Submit this form:**
**Online:** Upload through myMCHCP
**Fax:** 866-346-8785
**Mail:** PO Box 104355
Jefferson City, MO 65110-4355

**MCHCP Use Only**

**ST NSER**

*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): ___ ___/___ ___/___ ___ ___ ___