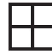
Missouri Consolidated Health Care Plan
573-751-0771 · 800-487-0771 · www.mchcp.org
832 Weathered Rock Court, Jefferson City, MO 65101



Foster Parent Enrollment

Level B Foster Parents

Submit this form:
Fax: 866-346-8785
Mail: PO Box 104355
Jefferson City, MO 65110-4355

MCHCP Use Only

ST ENR

Please print clearly

Section 1 – Subscriber Information

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:

County Where You Live:

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

Gender:
❑ Male ❑ Female

Marital Status:
❑ Single ❑ Married ❑ Widowed

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

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

Section 2 – Plan Continuation, Enrollment 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	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 3 – Dependents to be Enrolled, Changed or Cancelled

Action – **E:** Enroll **C:** Change **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 4 – Spouse Information

If your spouse is **eligible for insurance coverage through MCHCP as a Level B Foster Parent**, please complete the following information. This helps ensure you only have to meet one medical plan family deductible and out-of-pocket maximum. Each subscriber will have access to all medical information of the family unit.

Spouse's Name (Last, First, Middle Initial):

Spouse's Employer:

Spouse's Social Security Number:
___ ___ ___– ___ ___– ___ ___ ___ ___

Section 5 – Employer-Sponsored Health Insurance Coverage Attestation and Subscriber Authorization

I attest that I am not eligible for employer-sponsored health insurance coverage through my employer or my spouse's employer. If I become eligible for employer-sponsored health insurance coverage, I will notify MCHCP by phone, fax or mail immediately. MCHCP will cancel my coverage on the last day of the month in which I request cancellation or the last day of the month in which my other employer-sponsored coverage begins. I also hereby authorize the appropriate providers to release any documentation necessary to process claims/benefits for myself or my dependent(s). I authorize my chosen plan(s) to provide MCHCP the information necessary to validate benefits received and payment of claims to which I am entitled under the MCHCP plan.

Signature:

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

Revised: 09/2016