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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

2017 Open Enrollment Worksheet

Highway Patrol, MoDOT & Conservation
State Retirees — Dental and Vision Only

Submit this form:
Online: Upload through myMCHCP
Fax: 866-346-8785
Mail: Must be postmarked by Oct. 31, 2016
PO Box 104355, Jefferson City, MO 65110-4355

MCHCP Use Only
ST OEW

Section 1 – Subscriber Information

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

Address: ❑ New Address

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

County Where You Live:

Marital Status: ❑ Single ❑ Married ❑ Widowed

Preferred Email:

MCHCPid (Provide **either** MCHCPid or Social Security Number)
__ __ __ __ __ __ – __ __ __ __ __ __

or **Social Security Number**:
__ __ __ – __ __ – __ __ __ __

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

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

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

Section 2 – 2017 Plan Election(s) and Coverage Levels (Effective January 1, 2017)

Continue Dental Coverage

❑ Delta Dental — Dental Plan

Continue Vision Coverage

❑ NVA — Premium Vision Plan

❑ NVA — Basic Vision Plan

Dental	**Vision**
❑ Subscriber Only	❑ Subscriber Only
❑ Subscriber/Spouse	❑ Subscriber/Spouse
❑ Subscriber/Child(ren)	❑ Subscriber/Child(ren)
❑ Subscriber/Family	❑ Subscriber/Family

Cancel Dental and/or Vision Coverage

If you cancel, you are not eligible to enroll in MCHCP benefits in the future.

❑ Cancel Dental Coverage ❑ Cancel Vision Coverage

Section 3 – Spouse & Dependent Information

Action – E: Continue **D:** Cancel **Relationship – S:** Spouse **C:** Child **O:** Other (Stepchild, Grandchild, etc.) **Coverage – D:** Dental **V:** Vision

Action (Circle)	**Social Security Number**	**Name** (Last, First, Middle Initial)	**Date of Birth** (MM/DD/YYYY)	**Relationship** (Circle)	**Gender** (Circle)	**Coverage** (Circle)
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Section 4 – Subscriber Authorization

I hereby make the above designation(s) and authorize the deductions necessary to pay for the coverage selected. If my retirement check is not sufficient to cover the cost, I understand I will be direct billed. 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):
__ __/__ __/__ __ __ __