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

Enroll/Change/Cancel

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 ENR

Please print clearly

Section 1 – Subscriber Information

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

Address: ☐ New Address

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

Email: **County Where You Live:**

Gender: ☐ Male ☐ Female **Marital Status**: ☐ Single ☐ Married ☐ Widowed

Date of Marriage (MM/DD/YYYY):

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 – Add, Cancel, Drop Dependent or Transfer Coverage

☐ **Add Coverage:** Due to life event or loss of coverage (If adding yourself or spouse, you may complete Tobacco Attestation)

☐ **Cancel Coverage:**
☐ Subscriber *or* ☐ Dependent
☐ Medical ☐ Dental ☐ Vision

Reason:

☐ **Drop Dependent:** Give reason and date of occurrence
☐ Divorce (date):
☐ Death (date):
☐ Other Coverage:
☐ Other:

Retiree Only:
☐ Transfer to my own MCHCP coverage
☐ Transfer to my spouse's MCHCP coverage

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

Spouse's Social Security Number:

Section 3 – 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 4 – 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	**Social Security Number**	**Name** (Last, First, Middle Initial)	**Date of Birth** (MM/DD/YYYY)	**Relationship**	**Gender**	**Coverage**	**POE**
☐ 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 – Spouse Information

If your spouse is an active employee and **eligible for insurance coverage through MCHCP**, please complete the following information. This helps to ensure you only have to meet one medical plan family deductible and out-of-pocket maximum. MCHCP reserves the right to request proof of eligibility be provided at any time upon request.

Spouse's Name (Last, First, Middle Initial): **Spouse's Employer**: **Spouse's Social Security Number**: **Spouse's Date of Birth**

Section 6 – Subscriber Authorization

I hereby make the above designation(s) and authorize the deduction necessary to pay for the coverage elected. 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 to provide MCHCP the information necessary to validate benefits received and payment of claims to which I am entitled under the MCHCP plan.

Coverage Effective Date (MM/DD/YYYY): **Signature:** **Date** (MM/DD/YYYY):