Missouri Consolidated Health Care Plan

Retiree Enrollment

Highway Patrol, MoDOT, & Conservation
Dental & Vision Only

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

ST RET

Revised 10/2025

Section 1: Subscriber Information

Please print carefully.

Name (Last, First, MI): ☐ New Name

Address: ☐ New Address

City: **State**: **Zip Code**: **County Where You Live**:

Email Address:

Gender:
☐ Male ☐ Female

MCHCP ID:
OR
Social Security Number: - -

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

Primary Phone: ☐Home ☐Work ☐Cell
( ) -

Secondary Phone: ☐Home ☐Work ☐Cell
( ) -

Section 2: Continue, Cancel, Add, or Transfer Coverage

☐ **Continue Coverage**:
☐ Dental
☐ Vision

☐ **Cancel Coverage**:
☐ Dental
☐ Vision

☐ **Add Coverage**:
(Attach proof of prior coverage.)
☐ Dental
☐ Vision

☐ **Transfer** to my spouse's MCHCP coverage
(Spouse should submit an Enroll/Change/Cancel form to enroll you.)
Spouse's Name (Last, First, MI):

Spouse's Social Security Number: - -

Section 3: Enroll & Select Coverage Levels

Dental
☐ Delta Dental Plan
☐ S ☐ S/S ☐ S/C ☐ S/F

Vision
☐ NVA - Ultra Vision Plan
☐ NVA - Premium Vision Plan
☐ NVA - Basic Vision Plan
☐ S ☐ S/S ☐ S/C ☐ S/F

Coverage Levels: *S - Subscriber Only* *S/S - Subscriber & Spouse* *S/C - Subscriber & Children* *S/F - Subscriber & Family*

Section 4: Dependents to be Enrolled, Changed, or Canceled

Action: *E - Enroll C - Change D - Cancel* **Relation**: *S - Spouse C - Child O - Other (Stepchild, Grandchild, etc)* **Coverage**: *D - Dental V - Vision*
If adding a spouse or child, no coverage is provided until proof of eligibility is received. See www.mchcp.org for details. Use additional forms for more space.

Action	Social Security Number	Name (Last, First, MI)	Date of Birth (MM/DD/YYYY)	Relation	Gender	Coverage
☐☐☐ E C D	- -		/ /	☐☐☐ S C O	☐☐ M F	☐☐ D V
☐☐☐ E C D	- -		/ /	☐☐☐ S C O	☐☐ M F	☐☐ D V

Section 5: Cafeteria Plan Information and Member Authorization

I have been informed of the benefits and cost of each plan as well as the provisions and restrictions with respect to the procedures and changes in my election(s). I hereby make the above designation(s) and authorize the appropriate providers to release any documentation necessary to process claims/benefits for myself or my dependent(s). I authorize my chosen health plan to provide MCHCP the information necessary to validate benefits received and payment of claims to which I am entitled under the MCHCP plan. I acknowledge my first month's premium will be deducted from my last paycheck. If not sufficient, I will be billed for the balance. I also understand that if my benefit is sufficient, subsequent monthly retirement premiums will be deducted from my retirement benefit. If not, I will be billed monthly for the full premium amount. I also understand I have the following payment options.

☐ **My premiums are not collected pre-tax through the cafeteria plan, and I understand my first month's premium will be taken from my last paycheck.**

My premiums are collected pre-tax through the cafeteria plan:

☐ but I **do not** want to prepay retiree premiums. I understand that my first month's retiree premium will be taken from my last paycheck.

☐ and I ***would like*** to prepay retiree premiums through the cafeteria plan. I understand that my first month's retiree premium will be taken from my last paycheck. This form must be received at least 31 days prior to your retirement date if you are prepaying retiree premiums through the cafeteria plan.

The additional amount to be prepaid is **$**_____ and I'd like this amount to be:

☐ Divided between my last two paychecks ☐ Taken out of my lump-sum vacation payment *(Consult Human Resources for funds available)* ☐ A combination of both options

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

Signature:

Date (MM/DD/YYYY): / /