



**Missouri Consolidated Health Care Plan**  
 PO Box 104355 • 832 Weathered Rock Court  
 Jefferson City, MO 65110-4355  
 Phone: 800-487-0771 • 573-751-0771  
 Fax: 866-346-8785 • Web: www.mchcp.org

**EXAMPLE**  
 Retirement — Add Coverage

(Highway Patrol, MoDOT & Conservation)

**M-5a Retiree Health Insurance Election Form**

Please print in black or blue ink.

New Address:

**SECTION 1**

Social Security Number: **777-666-8888** Name: **John S.** (FIRST) (MI)

Address: (MAILING) **12576 Any Street** (CITY) **Columbia** (STATE) **MO** (ZIP CODE) **65201**

Daytime Phone Number: ( 573 ) **909-2222** Email Address: **John.Doe@mo.gov**

Alternate Phone Number: ( 573 ) **609-1222** County Code Where You LIVE: **0 1 5** County Name: **Camden**

**Be sure to use HOME phone number, not current work number.**

**SECTION 2**

Check all that apply: (If adding coverage, attach proof of prior coverage.)

CONTINUE dental coverage     CONTINUE vision coverage     TRANSFER coverage to spouse's SSN:  
 TERMINATE dental coverage     TERMINATE vision coverage  
 ADD dental coverage     ADD vision coverage

**IMPORTANT:** If adding a spouse or child, no coverage is provided until proof of eligibility is received. Refer to the Member Handbook or www.mchcp.org for details.

**SECTION 3**

**DENTAL** Coverage Level (check one):  Subscriber     Subscriber/Spouse     Subscriber/Child(ren)     Subscriber/Family

**VISION** Coverage Level (check one):  Subscriber     Subscriber/Spouse     Subscriber/Child(ren)     Subscriber/Family

**Complete section below for all dependents to be covered at retirement:**

Enroll/Continue	Subscriber/Dependent Social Security Number	Last Name	First Name	MI	Date of Birth (MM/DD/YYYY)	Sex M or F	Relation (Self, Spouse, Child)
<b>E</b>	<b>123-45-6789</b>	<b>Doe</b>	<b>Jane</b>	<b>A.</b>	<b>12/17/1949</b>	<b>F</b>	<b>Spouse</b>

**SECTION 4**

I have been informed of the benefits and procedures and changes in my election(s). I hereby make the above designation primary to process my or my dependent's claims/benefits. I authorize the deduction of my or my dependent's benefits received and payment of claims to which I am entitled under the Member Handbook. Conservation retirees will have monthly premium deducted from their retirement benefit. I also understand if I have sufficient payroll and my form has been received in a timely manner, one of the following options will apply.

I do not participate in the Cafeteria Plan. My premium will be deducted from my last payroll.

I do participate in the Cafeteria Plan but do not want to prepay retiree premiums. I understand that a portion of my first month's retiree premium will be deducted from my last payroll.

I do participate in the Cafeteria Plan and would like to prepay retiree premiums through the Cafeteria Plan. I understand a portion of my first month's premium will be deducted from my last payroll. This form must be received at least 30 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 2 payrolls.  
 Taken out of my lump sum vacation payment.  
 A combination of the above options.

Consult Human Resources/Payroll Officer for Funds Available.

**Attach certificate of Prior Coverage (See Proof-of-Insurance definition in Member Handbook.)**  
**Attach Proof-of-Eligibility documentation.**

**Complete the appropriate section. Please be sure to consult with your HR/Payroll Officer to verify the amount available for lump sum payment.**

**SECTION 4**

Retirement Date (MM/DD/YYYY): **1 1 0 1 2 0 0 9** Signature of Subscriber: *John S. Doe* Date: **10/03/2009**