



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 — Continue 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:	(FIRST) John	(MI) S.
	Address: (MAILING) 12576 Any Street		(CITY) Columbia	(STATE) (ZIP CODE) MO 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.

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:

SECTION 3	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)
	E	123-45-6789	Doe	Jane	A.	12/17/1949	F	Spouse

SECTION 4

I have been informed of the benefits and cost of the plan as well as the provisions and restrictions with respect to 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 my or my dependent's claims/benefits. I authorize the dental and/or vision 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 that a portion of the premium due to cover my first month as a retiree will be deducted from my last paycheck. MoDOT and Highway Patrol retirees will be billed for subsequent monthly premium. 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 I 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 I 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: \$ **1,150.00** 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.

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

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