



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

Please **print** in black or blue ink.

New Address:

**SECTION 1**

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

\*If you are enrolled in the county where you WORK, you must elect a plan available in the county where you LIVE. If you are required to change plans, please complete the following:

\* Medical Plan Code Number:

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

CONTINUE medical coverage  CONTINUE dental coverage  CONTINUE vision coverage  
 TERMINATE medical coverage  TERMINATE dental coverage  TERMINATE vision coverage  
 ADD medical coverage  ADD dental coverage  ADD vision coverage

TRANSFER coverage to spouse's SSN: \_\_\_\_\_

**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**

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

**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

If spouse is employed by the State of Missouri, complete the following:  
 Spouse's Name: \_\_\_\_\_ Spouse's SSN: \_\_\_\_\_

Are you or any dependents covered by Medicare?  YES  NO NOTE: Attach copies of all Medicare card(s).

**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)	PCP # (Mercy Southwest & South Central Only) Refer to Plan Directory
<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 my choice of beneficiary to receive and payment of claims to which I am entitled under the MCHCP plan. I understand that the amount of my retirement benefit will be deducted from subsequent paychecks if sufficient to cover the cost (semi-monthly pay periods - split across last two checks). If not sufficient, I will be billed for the balance. I also understand that if my Missouri State Employees' Retirement System benefit is sufficient, subsequent monthly retiree premiums will be deducted from my retirement benefit. If not, I will be billed monthly for the amount of the following options will apply.

I do not participate in the Cafeteria Plan

I do participate in the Cafeteria Plan

but **do not** want to prepay retiree premiums. I understand that my first month's retiree premium will be divided between my last two payrolls.

and **would like** to prepay retiree premiums through the Cafeteria Plan. I understand my first month's premium will be divided between my last two payrolls. *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.**

**Retirement Date (MM/DD/YYYY):** **1 1 0 1 2 0 0 9**

**Signature of Subscriber:** *John S. Doe*

**Date:** **10/03/2009**