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

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) (FIRST) John (MI) S.

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

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

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

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
- ❑ TERMINATE *medical* coverage
- ❑ ADD *medical* coverage
- ☑ CONTINUE *dental* coverage
- ❑ TERMINATE *dental* coverage
- ❑ ADD *dental* coverage
- ☑ CONTINUE *vision* coverage
- ❑ TERMINATE *vision* coverage
- ❑ ADD *vision* coverage
- ❑ TRANSFER coverage to spouse's SSN: ____

SECTION 3

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.

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

SECTION 4

I have been informed of the benefits and cost of each 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 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 that the premium due to cover my first month as a retiree 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 [...] been received in a timely manner, one of the following options will apply:

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

❑ **I *do not* participate in the C**[...] my last two payrolls.

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: $ 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.

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

Signature of Subscriber: *John S. Doe*

Date: 10/03/2009

(09/08)