M,

Missouri Consolidated Health Care Plan

Retiree Enrollment

State Members

Submit this form

 \square Online: Upload through myMCHCP

请 Fax: 866-346-8785 ⋈ *Mail*: PO Box 104355

Jefferson City, MO 65110-4355



Revised 04/2024

	Section 1: Subscriber In	formation						Ple	ease print	carefully.
Address: New Address Social Security Number: City: State: Zip Code: County Where You Live: Date of Birth (MM/DD/YYYY): / / Email Address: Gender: Primary Phone: Home Work! / / Are you or any dependents covered by Medicare? Male Female Secondary Phone: Home Work! / / Are you or any dependents covered by Medicare? Secondary Phone: Home Work! / / Are you or any dependents covered by Medicare? Secondary Phone: Home Work! / / Very (Attach copies of Medicare cards No	Name (Last, First, MI):				\[\big \]		_			
Canders: Gender: Gen	Address:	New Address					Ĩ		ity Numb	er:
Are you or any dependents covered by Medicare? Yes (Attach copies of Medicare cards) No	City:		State:	Zip Code:	County W	here You Live	: Da	ate of Birth (MM)		:
Are you or any dependents covered by Medicare? Yes (Attach copies of Medicare cards) No	Email Address:			_			Pr	rimary Phone:	Home [Work
Section 2: Continue, Cancel, Add, or Transfer Coverage Continue Coverage:	Are you or any dependents covered by Medicare?						() - Secondary Phone: □Home □Work □Cel			
Section 2: Continue Coverage: Cancel Coverage: Add Coverage: Add Coverage: Add Coverage: Cancel Coverage: Add Co							()		
Continue Coverage: Cancel Coverage: Add Coverage: Add Coverage: Cattach proof of prior coverage.} Transfer to my spouse's MCHCP coverage	•			erage				,		
Medical	☐ Continue Coverage: ☐ Cancel Co ☐ Medical ☐ Medical ☐ Dental ☐ Dental		rerage:		verage.)	(Spouse	ouse's Name (Last, First, MI):			
Coverage Levels: S - Subscriber Only S/S - Subscriber & Spouse S/C - Subscriber & Children S/F - Subscriber & Family * HSA Plan requires HSA Acceptance Form ** Available to Medicare Primary members only 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: M - Medical D - Dental V - V - V - V - V - V - V - V - V - V	Medical Denta Anthem □ TRICARE Supplement □ □ PPO 1250 □ Medicare Advantage □ □ PPO 750 Plan **			elta Dental Plan			□ NVA - Premium Vision Plan			
Action: <i>E - Enroll C - Change D - Cancel</i> Relation: <i>S - Spouse C - Child O - Other (Stepchild, Grandchild, etc)</i> Coverage: <i>M - Medical D - Dental V - V - V - V - V - V - V - V - V - V </i>	Coverage Levels:	S - Subscriber Or * HSA Plan requir	aly S/S - S es HSA Accept	ubscriber & Spou tance Form	se S/C -	Subscriber & Ch	nildren	S/F - Subscriber		S/F
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 hereby make the above designation(s) and authorize the appropriate providers to release any documentation necessary to process claims/benefits for myself or 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 divided between my last two paychecks. If not sufficient, I will be billed for the balance. I also understand that if my MOSERS benefit is sufficient, subsequent monthly retirement premiums will be deducted from my retirement benefit. If no 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 divided between my last two paychecks. 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 divided between my last two paychecks. and I would like to prepay retiree premiums through the cafeteria plan. I understand that my first month's retiree premium will be divided between my last two paychecks. 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 A combination of both options (Consult Human Resources for funds available)	Action: E - Enroll C - Change L If adding a spouse or child, no co Action Social Security Nu C C D	O - Cancel Relation	on: S - Spouse until proof of e	C - Child O - C eligibility is receiv		.mchcp.org for	details. Us	se additional forms (YY): Relation:	for more s	space.
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 hereby make the above designation(s) and authorize the appropriate providers to release any documentation necessary to process claims/benefits for myself or 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 divided between my last two paychecks. If not sufficient, I will be billed for the balance. I also understand that if my MOSERS benefit is sufficient, subsequent monthly retirement premiums will be deducted from my retirement benefit. If no 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 divided between my last two paychecks. 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 divided between my last two paychecks. and I would like to prepay retiree premiums through the cafeteria plan. I understand that my first month's 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 A combination of both options (Consult Human Resources for funds available)	ЕСБ <u></u>						1	S C O	ΜF	$M \supset V$
	I have been informed of the bene hereby make the above designatidependent(s). I authorize my cho entitled under the MCHCP plan. I balance. I also understand that if will be billed monthly for the full My premiums are not collected My premiums are collected pre-tabut I do not want to prepay rei paychecks. This form must be The additional amount to be p	fits and cost of ea on(s) and authorize sen health plan to acknowledge my my MOSERS bene premium amount. It pre-tax through to ax through the cafe tiree premiums. It use prepaid is \$	ch plan as well the appropriat provide MCHCf first month's pr fit is sufficient, I also understan the cafeteria plae eteria plan: understand that ugh the cafeteria I days prior to	as the provisions to providers to rel P the information remium will be div, subsequent mornd I have the followin, and I understamy first month's in plan. I understate your retirement	s and restriction ease any documecessary to a vided between athly retiremen owing paymen and my first more are tiree premit and that my fir date if you are and I'd like and vacation payment of the control of the cont	umentation nece validate benefits in my last two part premiums will t options. onth's premium um will be divide st month's retire prepaying retir this amount to by ment	essary to p s received aychecks. I I be deduct will be div ed between ee premiur ee premiur be:	rocess claims/bendand payment of class of the first sufficient, but the from my retires the from my retires the from my retires the first sufficient my and my last two payms will be divided the first through the case of the first sufficient s	efits for my aims to who will be billed ment benerate two pachecks. Detween my feteria plan	yself or my nich I am d for the fit. If not, I aychecks.
<u> </u>	Retirement Date (MM/DD/YYY			o ioi iuiius dv	aabro/	Date	(MM/DD/YYYY):			
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