Missouri Consolidated Health Care Plan

Notice of Special Enrollment Rights

Public Entity Account
(IRS Reg. 549801-6T(c))

Submit this form
Online: Upload through myMCHCP **Fax:**
800-834-5181
Mail: PO Box 104355
Jefferson City, MO 65110-4355

PE NSER

Revised 12/2021

Section 1: Subscriber Information

Name (Last, First, MI): ☐ New Name

_____ _____ _____

OR

MCHCP ID:
- _____

Social Security Number:
- -

Section 2: Notice to Subscriber

If you are declining enrollment with MCHCP for yourself or your dependents because of other health insurance coverage, you may be able to enroll yourself or your dependents in this plan in the future, provided that you request enrollment within 60 days after your other coverage ends.

If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself and your dependents, provided that you request enrollment within 31 days of the event.

I have read and understand the above notification. I understand that if I decline plan coverage, I can only obtain coverage during MCHCP's Open Enrollment period or because of the events listed above.

I am declining health care coverage under MCHCP due to the following reason(s):

Section 3: Conditions & Subscriber Authorization

Signature: _____

Date (MM/DD/YYYY): / /