Missouri Consolidated Health Care Plan
PO Box 104355 • 832 Weathered Rock Court
Jefferson City, MO 65110-4355
Phone: 800.487.0771 • 573.751.0771
Web: www.mchcp.org

Position pointer in form field. After entering text, press Tab or Shift+Tab to accept the form field change and go to the next or previous field. Single click check boxes to select options.

Print completed document, sign where appropriate and mail or FAX to MCHCP.

2008 SURVIVING CHILD Open Enrollment Worksheet

Reset Form

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

SECTION 1

New Address? ☒

Name:

Address:

City: State: Zip Code:

Email:

MCHCPid:

OR

SSN:

You will also need your PIN for online & phone enrollment.

SECTION 2

Please complete county code.

County Code Where You LIVE: Select from list

Daytime Phone Number:

SECTION 3

2008 PLAN ELECTIONS

Plan Code		Level of Coverage		
MEDICAL Plan Code:	**Plan Code** Refer to the Enrollment Guide for plan codes or enter "00" for no coverage.	**MEDICAL Level of Coverage Code:**	5	**Level of Coverage Code** Surviving Child - **5**
DENTAL Plan Code:		**DENTAL Level of Coverage Code:**	5	
VISION Plan Code:		**VISION Level of Coverage Code:**	5	

Your contribution was included with your letter that contained your PIN. Subtract that amount from the appropriate rate level of the 2008 rates (refer to the 2008 Enrollment Guide).

SECTION 4

SUBSCRIBER & DEPENDENT INFORMATION - List all members to be covered.

Relation Codes: Surviving Child - **5**

Relation Code	SSN	Date of Birth	Sex	Name Last	First	MI	PCP # (Mercy Southwest Only) Refer to Plan Directory
5							
5							
5							
5							
5							
5							
5							

I hereby make the above designation(s) and authorize the deduction necessary to pay for the coverage elected. I also hereby authorize the appropriate providers to release any documentation necessary to process my or my dependent's claims/benefits. I authorize my chosen plan to provide MCHCP the information necessary to validate benefits received and payment of claims to which I am entitled under the MCHCP plan.

Signature: **Date (MM/DD/YYYY):**

Choose **ONE** of the following ways to enroll:

Online - www.mchcp.org

By Fax - 866.346.8785

By Mail - Must be postmarked by OCTOBER 31, 2007