Missouri Consolidated Health Care Plan

2027 Open Enrollment Worksheet

State Members Effective
January 1, 2027

Submit this form
Online: Upload through myMCHCP
Fax: 866-346-8785
Mail: PO Box 104355
Jefferson City, MO 65110-4355
Must be postmarked by Oct. 31, 2026.

ST OEW

Revised 07/2026

Section 1: Subscriber Information

Please Print Clearly.

Name (Last, First, MI): ☐ New Name

Address: ☐ New Address

City: **State**: **Zip Code**:

Email Address:

Marital Status:
☐ Single ☐ Married ☐ Widowed

County Where You Live:

OR

MCHCP ID:

Social Security Number: - -

Date of Birth (MM/DD/YYYY): / /

Primary Phone: ☐Home ☐Work ☐Cell
( ) -

Secondary Phone: ☐Home ☐Work ☐Cell
( ) -

Section 2: Plan Elections & Coverage Levels

Medical

Anthem
☐ PPO 2500
☐ PPO 1250
☐ PPO 750

Selman & Co.
☐ TRICARE Supplement

HSA Plans (Online Only)
☐ S ☐S/S ☐S/C ☐S/F

Dental

Delta Dental
☐ Dental Plan

☐ S ☐ S/S ☐ S/C ☐ S/F

Vision

National Vision Administrators L.L.C (NVA)
☐ Ultra Vision Plan
☐ Premium Vision Plan
☐ Basic Vision Plan

☐ S ☐ S/S ☐ S/C ☐ S/F

Cancel Coverage
☐ Medical
☐ Dental
☐ Vision

Coverage Levels: S - Subscriber Only S/S - Subscriber & Spouse S/C - Subscriber & Children S/F - Subscriber & Family

Section 3: Dependents to be Enrolled, Changed, or Canceled

Action: *E - Enroll / Continue D - Cancel* **Relation**: *S - Spouse C - Child O - Other (Stepchild, Grandchild, etc)* **Coverage**: *M - Medical D - Dental V - Vision*
If adding a spouse or child, no coverage is provided until proof of eligibility is received. See www.mchcp.org for details. Use additional forms for more space.

Action	Social Security Number:	Name (Last, First, MI):	Date of Birth (MM/DD/YYYY):	Relation:	Gender:	Coverage:
☐ E ☐ D	- -		/ /	☐ S ☐ C ☐ O	☐ M ☐ F	☐ M ☐ D ☐ V
☐ E ☐ D	- -		/ /	☐ S ☐ C ☐ O	☐ M ☐ F	☐ M ☐ D ☐ V
☐ E ☐ D	- -		/ /	☐ S ☐ C ☐ O	☐ M ☐ F	☐ M ☐ D ☐ V
☐ E ☐ D	- -		/ /	☐ S ☐ C ☐ O	☐ M ☐ F	☐ M ☐ D ☐ V

Section 4: Married State Employee Roll-Up Option

If your spouse is also eligible for MCHCP medical coverage and either of you enroll children for medical coverage, complete the information below to ensure your family is subject to one combined yearly family deductible and out-of-pocket maximum. **In order to finalize this process, your eligible spouse must provide the same information when they enroll.** Each spouse must enroll in the same plan.

Spouse's Name (Last, First, MI): **Spouse's Employer**: **Spouse's SSN**: - -

Section 5: Subscriber Authorization

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 claims/benefits for myself or my dependent(s). I authorize my chosen plan(s) to provide MCHCP the information necessary to validate benefits and payment of claims to which I am entitled under the MCHCP plan.

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