Missouri Consolidated Health Care Plan

2027 Open Enrollment Worksheet

State Retirees 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

______________________ ______________________ ______

MCHCP ID: ________ - ________

OR

Social Security Number: ______ - ______ - ______

Address: ☐ New Address

____

City: ______________________ **State**: ________ **Zip Code**: ________

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

Email Address: ____

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

Marital Status: ☐ Single ☐ Married ☐ Widowed

County Where You Live: ______________________

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

Section 2: Plans & Coverage Levels

Continued Medical Coverage for Medicare-Eligible Members
Retirees eligible for Medicare will remain enrolled or be enrolled in the Medicare Advantage Plan. To opt out, you must cancel your MCHCP medical coverage, which will also cancel pharmacy coverage. Dental and vision coverage will continue automatically unless canceled during Open Enrollment. Retirees cannot add new plans during Open Enrollment.

Continue Medical Coverage for Non–Medicare-Eligible Members	Continue Dental Coverage	Continue Vision Coverage	Cancel Coverage
Current coverage will automatically continue. To change plans, complete this form and return to MCHCP by Oct. 31, 2026. Anthem: ☐ PPO 2500 ☐ PPO 1250 ☐ PPO 750 Selman & Co.: ☐ TRICARE Supplement [illegible] ***HSA Plans (Online Only)*** ☐ S ☐ S/S ☐ S/C ☐ S/F	Delta Dental ☐ Dental Plan ☐ S ☐ S/S ☐ S/C ☐ S/F	National Vision Administrators L.L.C (NVA) ☐ Ultra Vision Plan ☐ Premium Vision Plan ☐ Basic Vision Plan ☐ S ☐ S/S ☐ S/C ☐ S/F	☐ Medical ☐ Dental ☐ Vision *Retirees who cancel coverage are not eligible to enroll at a later date.*

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

Section 3: Dependents to be Continued or Canceled

Action: *C - Continue D - Cancel* **Relation**: *S - Spouse C - Child O - Other (Stepchild, Grandchild, etc)* **Coverage**: *M - Medical D - Dental V - Vision*
Use additional forms for more space.

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

Section 4: Subscriber Authorization

I hereby make the above designation(s) and authorize the deduction necessary to pay for the coverage elected. If my retirement check is not sufficient to cover the cost, I understand I will be direct billed. 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): ____ / ____ / ______