



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

Address: ☐ New Address

City: State: Zip Code:

Email Address:

Marital Status: County Where You Live:

☐ Single ☐ Married ☐ Widowed

MCHCP ID:

OR

Social Security Number:

Date of Birth (MM/DD/YYYY):

Primary Phone: ☐ Home ☐ Work ☐ Cell

() -

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

Current coverage will automatically continue. To change plans, complete this form and return to MCHCP by Oct. 31, 2026.

Anthem Selman & Co.
☐ PPO 2500 ☐ TRICARE Supplement
☐ PPO 1250 ☐ C2W a 1001-100 a SY0511a
☐ PPO 750 ☐ SY0211SR 1y1- CWL/ 1w9 tti-y
HSA Plans (Online Only)
☐ S ☐ S/S ☐ S/C ☐ S/F

Continue Dental Coverage

Delta Dental
☐ Dental Plan

☐ S ☐ S/S ☐ S/C ☐ S/F

Continue Vision Coverage

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

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):