



Missouri Consolidated Health Care Plan

2027 Open Enrollment Worksheet

Highway Patrol, MoDOT, & Conservation
Dental & Vision Only - 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

Missouri Consolidated Health Care Plan

Name (Last, First, MI): ☐ New Name

Address: ☐ New Address

City: State: Zip Code:

Email Address:

Marital Status: ☐ Single ☐ Married ☐ Widowed

County Where You Live:

MCHCP ID:

OR

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

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

☐ 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: 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.

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

Section 4: 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): _____

MCHCP 832 Weathered Rock Court Jefferson City, MO 65101 573-751-0771 800-487-0771 www.mchcp.org

Member Services Phone Hours: 8:30 a.m.-12 p.m. & 1-4:30 p.m., Monday-Friday (except State holidays)