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

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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):