



Missouri Consolidated Health Care Plan

2027 Open Enrollment Worksheet

Highway Patrol, MoDOT, Conservation, & State Retirees
Dental & Vision Only - Effective Jan. 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: Plans & Coverage Levels

Continue Dental

Delta Dental

☐ Dental Plan

☐ S ☐ S/S ☐ S/C ☐ S/F

Continue 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

Retirees who cancel dental and/or vision 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: D - Dental V - Vision

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

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)