Missouri Consolidated Health Care Plan

2027 Open Enrollment Worksheet

Level B Foster Parents
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

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

Medical

Anthem
☐ PPO 2500
☐ PPO 1250
☐ PPO 750

Selman & Co.
☐ TRICARE Supplement

HSA Plans (Online Only)

☐S ☐S/S ☐S/C ☐S/F

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
☐ Medical
☐ 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**: *M - Medical 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. Use additional forms for more space.

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

Section 4: Married Level B Foster Parent Roll-Up Option

If your spouse is also a Level B Foster Parent and eligible for MCHCP medical coverage and either of you enroll children for medical coverage, complete the information below to ensure your family is subject to one combined yearly family deductible and out-of-pocket maximum. **In order to finalize this process, your eligible spouse must provide the same information when they enroll.** Each spouse must enroll in the same plan.

Spouse's Name (Last, First, MI):

Spouse's SSN: - -

Section 5: Subscriber Authorization

I attest that I am not eligible for employer-sponsored health insurance coverage through my employer or my spouse's employer. If I become eligible for employer-sponsored health insurance coverage, I will notify MCHCP by phone, fax, or mail immediately. MCHCP will cancel my coverage on the last day of the month in which I request cancellation or the last day of the month in which my other employer-sponsored coverage begins. 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): / /