



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

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

Medical	Dental	Vision	Cancel Coverage
☐ Anthem ☐ PPO 2500 ☐ PPO 1250 ☐ PPO 750 ☐ Selman & Co. ☐ TRICARE Supplement ☐ C2W a10u1-u8 aSY0Sua ☐ Syn2ttSR iy1- cw1/!w9 tfl-y	☐ Delta Dental ☐ Dental Plan	☐ National Vision Administrators L.L.C (NVA) ☐ Ultra Vision Plan ☐ Premium Vision Plan ☐ Basic Vision Plan	☐ Medical ☐ Dental ☐ Vision
HSA Plans (Online Only) ☐ S ☐ S/S ☐ S/C ☐ S/F	☐ S ☐ S/S ☐ S/C ☐ S/F	☐ S ☐ S/S ☐ S/C ☐ S/F	

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):