



Missouri Consolidated Health Care Plan

Enroll/Change/Cancel

Highway Patrol, MoDOT, & Conservation
Dental & Vision Only

Submit this form

☐ Online: Upload through myMCHCP

☐ Fax: 866-346-8785

☒ Mail: PO Box 104355

Jefferson City, MO 65110-4355

ST ENR

Revised 11/2025

Section 1: Subscriber Information

Please print carefully.

Name (Last, First, MI):

☐ New Name

Address:

☐ New Address

City:

State:

Zip Code:

Email Address:

County Where You Live:

Gender:

Marital Status:

Date of Marriage (MM/DD/YYYY):

☐ Male ☐ Female

☐ Single ☐ Married ☐ Widowed

MCHCP ID:

OR

Social Security Number:

Date of Birth (MM/DD/YYYY):

Primary Phone: ☐ Home ☐ Work ☐ Cell

() -

Secondary Phone: ☐ Home ☐ Work ☐ Cell

() -

Section 2: Add/Cancel Coverage, Drop Dependent, or Transfer Coverage

☐ Add Coverage:

Due to life event or loss of coverage

☐ Cancel Coverage:

☐ Subscriber ☐ Dependent

☐ Dental ☐ Vision

Reason:

☐ Drop Dependent: Give Reason & Date

☐ Divorce / /

☐ Death / /

☐ Other Coverage

☐ Other

☐ Transfer: Retiree Only

☐ to my own MCHCP coverage.

☐ to my spouse's MCHCP coverage.

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

Spouse's Social Security Number:

- -

Section 3: Enroll & Select Coverage Levels

Dental

☐ Delta Dental Plan

☐ S ☐ S/S ☐ S/C ☐ S/F

Vision

☐ NVA - Ultra Vision Plan

☐ NVA - Premium Vision Plan

☐ NVA - Basic Vision Plan

☐ 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 4: Dependents to be Enrolled, Changed, or Canceled

Action: E - Enroll C - Change 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. Use additional forms for more space.

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

Section 5: 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.

Coverage Effective Date (MM/DD/YYYY):

Signature:

Date (MM/DD/YYYY):