



Missouri Consolidated Health Care Plan

Survivor Enrollment

State Members

Submit this form

☐ **Online:** Upload through myMCHCP

☐ **Fax:** 866-346-8785

☒ **Mail:** PO Box 104355

Jefferson City, MO 65110-4355

ST SVR

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:

☐ Male ☐ Female

MCHCP ID:

OR

Social Security Number:

Date of Birth (MM/DD/YYYY):

Primary Phone: ☐ Home ☐ Work ☐ Cell

() -

Secondary Phone: ☐ Home ☐ Work ☐ Cell

() -

Section 2: Deceased Subscriber Information

Name (Last, First, MI):

SSN:

Date of Death:

Section 3: Continue or Add Coverage

☐ Continue Coverage:

☐ Medical ☐ Dental ☐ Vision

☐ Add Coverage:

(Attach proof of prior coverage.)

☐ Medical ☐ Dental ☐ Vision

Section 4: Plan Selection & Coverage Levels

Medical

Anthem ☐ TRICARE Supplement

☐ PPO 1250 ☐ Medicare Advantage

☐ PPO 750 Plan **

☐ HSA Plan *

☐ S ☐ S/S ☐ S/C ☐ S/F

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

* HSA Plan requires HSA Acceptance Form ** Available to Medicare Primary members only

Section 5: 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: 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 ☐ C ☐ D	- -		/ /	☐ S ☐ C ☐ O	☐ M ☐ F	☐ M ☐ D ☐ V
☐ E ☐ C ☐ D	- -		/ /	☐ S ☐ C ☐ O	☐ M ☐ F	☐ M ☐ D ☐ V
☐ E ☐ C ☐ D	- -		/ /	☐ S ☐ C ☐ O	☐ M ☐ F	☐ M ☐ D ☐ V

Section 6: Subscriber Authorization

I have attached a personal check in the amount of \$ _____ to pay for my first month's premium.

I hereby certify the above information is true and correct, and authorize the deduction from my survivor benefit check necessary to pay for coverage elected (if applicable).

Signature:

Date (MM/DD/YYYY):