



Missouri Consolidated Health Care Plan

Terminated Vested Enrollment

State Members

Submit this form

☐ **Online:** Upload through myMCHCP

☐ **Fax:** 866-346-8785

☒ **Mail:** PO Box 104355

Jefferson City, MO 65110-4355

ST VES

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: Continue, Cancel, Add, or Transfer Coverage

☐ Continue Coverage:

- ☐ Medical
☐ Dental
☐ Vision

☐ Cancel Coverage:

- ☐ Medical
☐ Dental
☐ Vision

☐ Add Coverage:

(Attach proof of prior coverage.)

- ☐ Medical
☐ Dental
☐ Vision

☐ Transfer to my spouse's MCHCP coverage

(Spouse should submit an Enroll/Change/Cancel form to enroll you.)

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

Spouse's Social Security Number:

Section 3: Plan Selection & Coverage Levels

Medical

- Anthem ☐ TRICARE Supplement
☐ PPO 1250 ☐ Medicare Advantage Plan **
☐ PPO 750
☐ 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 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: 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
☐ 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 5: Subscriber Authorization

I hereby request enrollment in MCHCP for myself and eligible qualified dependents listed on this form and agree to pay the premium as required. I also acknowledge that I will be billed for the premium each month and that failure to pay future billing will result in termination of coverage.

Signature:

Date (MM/DD/YYYY):