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 04/2024

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**:
☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed

Date of Marriage (MM/DD/YYYY): / /

OR

MCHCP ID: -

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 - 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): / /