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 09/2021

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

OR

MCHCP ID:

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
☐ PPO 1250
☐ PPO 750
☐ HSA Plan *
☐ TRICARE Supplement
☐ Medicare Advantage Plan **
☐ S ☐ S/S ☐ S/C ☐ S/F

Dental
☐ MetLife 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*
* 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**: *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): / /