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 10/2020

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
☐ 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 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	☐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 6: 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 reequired. 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 caverage.

Signature:

Date (MM/DD/YYYY): / /