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 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**: **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 - 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*

## 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): / /