Missouri Consolidated Health Care Plan

# Survivor Enrollment

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 SVR**

*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

*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**:
☐ Dental ☐ Vision

☐ **Add Coverage**:
(Attach proof of prior coverage.)
☐ Dental ☐ Vision

## Section 4: Plan Selection & 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 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 | ☐ D ☐ V |
| ☐ E ☐ C ☐ D | - - | | / / | ☐ S ☐ C ☐ O | ☐ M ☐ F | ☐ D ☐ V |
| ☐ E ☐ C ☐ D | - - | | / / | ☐ S ☐ C ☐ O | ☐ M ☐ F | ☐ 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): / /