Missouri Consolidated Health Care Plan

Enroll/Change/Cancel

State Members

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. (If adding self or spouse, you may complete the Tobacco Attestation.)

☐ **Cancel Coverage**:
☐ Subscriber ☐ Dependent
☐ Medical ☐ 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

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

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*
* 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**: *M - Medical 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

Section 5: Spouse Information

If your spouse is an active employee eligible for MCHCP insurance coverage, complete the following information. This helps to ensure you only have to meet one medical plan family deductible and out-of-pocket maximum. MCHCP reserves the right to request proof of eligibility be provided at any time upon request.

Spouse's Name (Last, First, MI): **Spouse's Employer**: **Spouse's SSN**: - - **Spouse's Date of Birth**: / /

Section 6: 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): / /