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Missouri Consolidated Health Care Plan
573-751-0771 · 800-487-0771 · www.mchcp.org
832 Weathered Rock Court, Jefferson City, MO 65101

Enroll/Change/Cancel

Highway Patrol, MoDOT & Conservation
Dental and Vision Only

Submit this form:
Online: Upload through myMCHCP
Fax: 866-346-8785
Mail: PO Box 104355
Jefferson City, MO 65110-4355

Please print clearly

MCHCP Use Only

ST ENR

Section 1 – Subscriber Information

Name (Last, First, Middle Initial): ❑ New Name

MCHCPid (Provide **either** MCHCPid or Social Security Number)
___ ___ ___ ___ ___ – ___ ___ ___ ___ ___

Address: ❑ New Address

or **Social Security Number**:
___ ___ ___ – ___ ___ – ___ ___ ___ ___

City: **State**: **ZIP Code**:

Date of Birth (MM/DD/YYYY):
___ ___/___ ___/___ ___ ___ ___

Email:

County Where You Live:

Primary Phone Number: ❑ Home ❑ Work ❑ Cell
(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

Gender: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Widowed

Date of Marriage (MM/DD/YYYY):
___ ___/___ ___/___ ___ ___ ___

Secondary Phone Number: ❑ Home ❑ Work ❑ Cell
(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

Section 2 – Add, Cancel, Drop Dependent or Transfer Coverage

❑ **Add Coverage**
Due to life event or loss of coverage

❑ **Cancel Coverage:**
❑ Subscriber *or* ❑ Dependent
❑ Dental ❑ Vision

Reason:

❑ **Drop Dependent:** Give reason and date of occurrence
❑ Divorce (date): __ __/__ __/__ __ __ __
❑ Death (date): __ __/__ __/__ __ __ __
❑ Other Coverage:
❑ Other:

Retiree Only:
❑ Transfer to my own MCHCP coverage
❑ Transfer to my spouse's MCHCP coverage

Spouse's Name (Last, First, Middle Initial):

Spouse's Social Security Number:
___ ___ ___ – ___ ___ – ___ ___ ___ ___

Section 3 – Plan Continuation, Enrollment and Coverage Levels

Enroll in a Dental Plan
❑ Delta Dental—Dental Plan

Enroll in a Vision Plan
❑ NVA—Premium Vision Plan
❑ NVA—Basic Vision Plan

Dental	**Vision**
❑ Subscriber Only	❑ Subscriber Only
❑ Subscriber/Spouse	❑ Subscriber/Spouse
❑ Subscriber/Child(ren)	❑ Subscriber/Child(ren)
❑ Subscriber/Family	❑ Subscriber/Family

Section 4 – Dependents to be Enrolled, Changed or Cancelled

Action – **E:** Enroll **C:** Change **D:** Cancel **Relationship** – **S:** Spouse **C:** Child **O:** Other (Stepchild, Grandchild, etc.) **Coverage** – **D:** Dental **V:** Vision
If proof of eligibility has been previously provided for the dependent, mark the box in the **POE** column.

Action (Circle)	**Social Security Number**	**Name** (Last, First, Middle Initial)	**Date of Birth** (MM/DD/YYYY)	**Relationship** (Circle)	**Gender** (Circle)	**Coverage** (Circle)	**POE**
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	❑
E C D	__ __ __–__ __–__ __ __ __		__ __/__ __/__ __ __ __	S C O	M F	D V	❑

If adding a spouse or child, no coverage is provided until proof of eligibility is received. Refer to www.mchcp.org for details. If more space is needed, please use additional forms.

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 to provide MCHCP the information necessary to validate benefits received and payment of claims to which I am entitled under the MCHCP plan.

Coverage Effective Date (MM/DD/YYYY): ___ ___/___ ___/___ ___ ___ ___

Signature:

Date (MM/DD/YYYY): ___ ___/___ ___/___ ___ ___ ___

Revised: 12/2014