



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 10/2021

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: 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
 MetLife Dental Plan

Vision
 NVA - Premium Vision Plan
 NVA - Basic Vision Plan

S S/S S/C S/F 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:
<input type="checkbox"/> E <input type="checkbox"/> C <input type="checkbox"/> D	_____-_____-____	_____	____/____/____	<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> O	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> D <input type="checkbox"/> V
<input type="checkbox"/> E <input type="checkbox"/> C <input type="checkbox"/> D	_____-_____-____	_____	____/____/____	<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> O	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> D <input type="checkbox"/> V
<input type="checkbox"/> E <input type="checkbox"/> C <input type="checkbox"/> D	_____-_____-____	_____	____/____/____	<input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> O	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> D <input type="checkbox"/> 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): ____/____/____