



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 04/2024

## 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

Delta Dental Plan

S  S/S  S/C  S/F

### Vision

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:
<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):