



Missouri Consolidated Health Care Plan

# Terminated Vested 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 VES

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: Continue, Cancel, Add, or Transfer Coverage

### Continue Coverage:

- Dental
- Vision

### Cancel Coverage:

- Dental
- Vision

### Add Coverage:

(Attach proof of prior coverage.)

- Dental
- Vision

### Transfer to my spouse's MCHCP coverage

(Spouse should submit an Enroll/Change/Cancel form to enroll you.)

Spouse's Name (Last, First, MI):

Spouse's Social Security Number:

## Section 3: Plan Selection & Coverage Levels

### Dental

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

## Section 5: Subscriber Authorization

I hereby request enrollment in MCHCP for myself and eligible qualified dependents listed on this form and agree to pay the premium as required. I also acknowledge that I will be billed for the premium each month and that failure to pay future billing will result in termination of coverage.

Signature:

Date (MM/DD/YYYY):