



Submit this form

Online: Upload through myMCHCP

Fax: 866-346-8785

Mail: PO Box 104355

Jefferson City, MO 65110-4355



Revised 04/2024

Instructions

To receive the monthly premium reduction, subscriber and spouse must submit either the Tobacco-Free or Quit Tobacco Promise form. Separate forms for the subscriber and spouse may be submitted.

Section 1: Subscriber Information

Name (Last, First, MI): [] New Name

Address: [] New Address

City: State: Zip Code:

MCHCP ID: OR Social Security Number:

Date of Birth (MM/DD/YYYY):

Section 2: Spouse Information (If Eligible)

Name (Last, First, MI):

Social Security Number:

Section 3: Tobacco-Free Promise (for Non-Tobacco Users)

- 1. I have not used tobacco products in the past 3 months and will not use tobacco products throughout the remainder of the year covered by this incentive.
2. I understand that it is my responsibility to submit a Tobacco-Free Promise form either online, by mail, by fax, uploaded through my myMCHCP account, or in person.
3. I understand that if I am adding medical coverage, then MCHCP must receive this form within thirty-one (31) days of my medical coverage effective date for the incentive to be effective on the same date that my medical coverage is effective.
4. I understand that the incentive is for a set period of time and may need to be renewed upon notice.
5. I understand that if I begin using tobacco products, I must notify MCHCP by phone, fax, or mail the next business day.
6. I understand that this is a legally binding document and that under Missouri law (§103.057 RSMo) I could be subject to fines or imprisonment if I knowingly make a false statement in an attempt to defraud MCHCP.

Section 4: Signature(s)

[] I attest to being tobacco-free.

Subscriber Signature:

Date (MM/DD/YYYY):

[] I attest to being tobacco-free.

Spouse Signature:

Date (MM/DD/YYYY):