



Missouri Consolidated Health Care Plan  
**2027 Open Enrollment Worksheet**

Level B Foster Parents  
Effective January 1, 2027

**Submit this form**

☐ **Online:** Upload through myMCHCP

☐ **Fax:** 866-346-8785

☒ **Mail:** PO Box 104355

Jefferson City, MO 65110-4355

Must be postmarked by Oct. 31, 2026.

**ST OEW**

Revised 07/2026

**Section 1: Subscriber Information**

*t t S I - a S P u u y c t S I - u i e*

**Name** (Last, First, MI): ☐ New Name

**Address:** ☐ New Address

**City:** **State:** **Zip Code:**

**Email Address:**

**Marital Status:** **County Where You Live:**

☐ Single ☐ Married ☐ Widowed

**MCHCP ID:**

**OR** ☐ -

**Social Security Number:**

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

**Primary Phone:** ☐ Home ☐ Work ☐ Cell

( ) -

**Secondary Phone:** ☐ Home ☐ Work ☐ Cell

( ) -

**Section 2: Plan Elections & Coverage Levels**

**Medical**

Anthem Selman & Co.  
☐ PPO 2500 ☐ TRICARE Supplement  
☐ PPO 1250 ☐ C2U a i b u i - u e a S Y o S u a  
☐ PPO 750 ☐ S y n e t t S R i y i - c w l / ! w 9 t t l - y

**HSA Plans (Online Only)**

☐ S ☐ S/S ☐ S/C ☐ S/F

**Dental**

Delta Dental  
☐ Dental Plan

☐ S ☐ S/S ☐ S/C ☐ S/F

**Vision**

National Vision Administrators L.L.C (NVA)  
☐ Ultra Vision Plan  
☐ Premium Vision Plan  
☐ Basic Vision Plan

☐ S ☐ S/S ☐ S/C ☐ S/F

**Cancel Coverage**

☐ Medical  
☐ Dental  
☐ Vision

**Coverage Levels:** S - Subscriber Only S/S - Subscriber & Spouse S/C - Subscriber & Children S/F - Subscriber & Family

**Section 3: Dependents to be Enrolled, Changed, or Canceled**

**Action:** E - Enroll / Continue D - Cancel **Relation:** S - Spouse C - Child O - Other (Stepchild, Grandchild, etc) **Coverage:** M - Medical D - Dental V - Vision  
If adding a spouse or child, no coverage is provided until proof of eligibility is received. See [www.mchcp.org](http://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"/> D | - -                     |                         | / /                         | <input type="checkbox"/> S <input type="checkbox"/> C <input type="checkbox"/> O | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> V |
| <input type="checkbox"/> E <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"/> M <input type="checkbox"/> D <input type="checkbox"/> V |
| <input type="checkbox"/> E <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"/> M <input type="checkbox"/> D <input type="checkbox"/> V |
| <input type="checkbox"/> E <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"/> M <input type="checkbox"/> D <input type="checkbox"/> V |

**Section 4: Married Level B Foster Parent Roll-Up Option**

If your spouse is also a Level B Foster Parent and eligible for MCHCP medical coverage and either of you enroll children for medical coverage, complete the information below to ensure your family is subject to one combined yearly family deductible and out-of-pocket maximum. **In order to finalize this process, your eligible spouse must provide the same information when they enroll.** Each spouse must enroll in the same plan.

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

**Spouse's SSN:**

**Section 5: Subscriber Authorization**

I attest that I am not eligible for employer-sponsored health insurance coverage through my employer or my spouse's employer. If I become eligible for employer-sponsored health insurance coverage, I will notify MCHCP by phone, fax, or mail immediately. MCHCP will cancel my coverage on the last day of the month in which I request cancellation or the last day of the month in which my other employer-sponsored coverage begins. 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(s) to provide MCHCP the information necessary to validate benefits and payment of claims to which I am entitled under the MCHCP plan.

**Signature:**

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