Missouri Consolidated Health Care Plan

Survivor Enrollment

State Members

Submit this form
Online: Upload through myMCHCP
Fax: 866-346-8785
Mail: PO Box 104355
Jefferson City, MO 65110-4355

ST SVR

Revised 11/2025

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

OR

MCHCP ID:

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**:
☐ Medical ☐ Dental ☐ Vision

☐ **Add Coverage**:
(Attach proof of prior coverage.)
☐ Medical ☐ Dental ☐ Vision

Section 4: Plan Selection & Coverage Levels

Medical

Anthem
☐ PPO 1250
☐ PPO 750
☐ HSA Plan *
☐ TRICARE Supplement
☐ Medicare Advantage Plan **

☐ S ☐ S/S ☐ S/C ☐ S/F

Dental

☐ Delta Dental Plan

☐ S ☐ S/S ☐ S/C ☐ S/F

Vision

☐ NVA - Ultra Vision Plan
☐ 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*
* HSA Plan requires HSA Acceptance Form ** Available to Medicare Primary members only

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**: *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 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:
☐ E ☐ C ☐ D	- -		/ /	☐ S ☐ C ☐ O	☐ M ☐ F	☐ M ☐ D ☐ V
☐ E ☐ C ☐ D	- -		/ /	☐ S ☐ C ☐ O	☐ M ☐ F	☐ M ☐ D ☐ V
☐ E ☐ C ☐ D	- -		/ /	☐ S ☐ C ☐ O	☐ M ☐ F	☐ M ☐ D ☐ 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):