Missouri Consolidated Health Care Plan

Terminated Vested Enrollment

State Members

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

ST VES

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: Continue, Cancel, Add, or Transfer Coverage

☐ **Continue Coverage**:
- ☐ Medical
- ☐ Dental
- ☐ Vision

☐ **Cancel Coverage**:
- ☐ Medical
- ☐ Dental
- ☐ Vision

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

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 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**: *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
☐ 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 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): / /