Missouri Consolidated Health Care Plan

Foster Parent Enrollment

Level B Foster Parents

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

ST ENR

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: **Marital Status**:

☐ Male ☐ Female ☐ Single ☐ Married ☐ Widowed

Date of Marriage (MM/DD/YYYY): / /

OR

MCHCP ID: -

Social Security Number: - -

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

Primary Phone: ☐ Home ☐ Work ☐ Cell

( ) -

Secondary Phone: ☐ Home ☐ Work ☐ Cell

( ) -

Section 2: Enroll & Select Coverage Levels

Medical	Dental	Vision
Anthem ☐ TRICARE Supplement	☐ Delta Dental Plan	☐ NVA - Ultra Vision Plan
☐ PPO 1250		☐ NVA - Premium Vision Plan
☐ PPO 750		☐ NVA - Basic Vision Plan
☐ HSA Plan *		
☐ S ☐ S/S ☐ S/C ☐ S/F	☐ S ☐ S/S ☐ S/C ☐ S/F	☐ 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

Section 3: 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 4: Spouse Information

If your spouse is eligible for MCHCP insurance coverage as a Level B Foster Parent, please complete the following information. This helps to ensure you only have to meet one medical plan family deductible and out-of-pocket maximum. Each subscriber will have access to all medical information of the family unit.

Spouse's Name (Last, First, MI): **Spouse's Employer**: **Spouse's SSN**: - - **Spouse's Date of Birth**: / /

Section 5: Employer-Sponsored Health Insurance Coverage Attestation and 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): / /