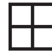
Missouri Consolidated Health Care Plan
573-751-0771 · 800-487-0771 · www.mchcp.org
832 Weathered Rock Court, Jefferson City, MO 65101



Survivor Enrollment

Highway Patrol, MoDOT & Conservation
Dental and Vision Only

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

MCHCP Use Only

ST SVR

Please print clearly

Section 1 – Survivor Information

Are you or any dependents covered by Medicare? ❑ Yes (Attach copies of Medicare cards) ❑ No

Name (Last, First, Middle Initial): ❑ New Name ____________________

Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Address: ❑ New Address ____________________

City: ____________ **State**: ______ **ZIP Code**: ___ ___ ___ ___ ___

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

Email: ____________________

Primary Phone Number: ❑ Home ❑ Work ❑ Cell
(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

County Where You Live: ____________________

Gender: ❑ Male ❑ Female

Secondary Phone Number: ❑ Home ❑ Work ❑ Cell
(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

Section 2 – Deceased Subscriber Information (Attach copy of death certificate)

Name (Last, First, Middle Initial): ____________________

Date of Death (MM/DD/YYYY): ___ ___/___ ___/___ ___ ___ ___

Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Section 3 – Continue or Add Coverage

❑ **Continue Coverage**
❑ Dental ❑ Vision

❑ **Add Coverage** (Attach proof of prior coverage)
❑ Dental ❑ Vision

Section 4 – Plan Selections and Coverage Levels

Enroll in a Dental Plan

❑ Delta Dental—Dental Plan

Enroll in a Vision Plan

❑ NVA—Premium Vision Plan

❑ NVA—Basic Vision Plan

Dental	**Vision**
❑ Survivor Only	❑ Survivor Only
❑ Survivor & Child(ren)	❑ Survivor & Child(ren)
❑ Child(ren) Only	❑ Child(ren) Only

Section 5 – Survivor and Dependents to be Covered

Action – **E:** Enroll **C:** Continue **Relationship** – **S:** Spouse **C:** Child **O:** Other (Stepchild, Grandchild, etc.) **Coverage** – **D:** Dental **V:** Vision
If proof of eligibility has been previously provided for the dependent, mark the box in the **POE** column.

Action (Circle)	**Social Security Number**	**Name** (Last, First, Middle Initial)	**Date of Birth** (MM/DD/YYYY)	**Relationship** (Circle)	**Gender** (Circle)	**Coverage** (Circle)	**POE**
E C	___ ___ ___–___ ___–___ ___ ___ ___		___ ___/___ ___/___ ___ ___ ___	S C O	M F	D V	❑
E C	___ ___ ___–___ ___–___ ___ ___ ___		___ ___/___ ___/___ ___ ___ ___	S C O	M F	D V	❑
E C	___ ___ ___–___ ___–___ ___ ___ ___		___ ___/___ ___/___ ___ ___ ___	S C O	M F	D V	❑
E C	___ ___ ___–___ ___–___ ___ ___ ___		___ ___/___ ___/___ ___ ___ ___	S C O	M F	D V	❑
E C	___ ___ ___–___ ___–___ ___ ___ ___		___ ___/___ ___/___ ___ ___ ___	S C O	M F	D V	❑

If adding a child, no coverage is provided until proof of eligibility is received. Refer to www.mchcp.org for details. If more space is needed, please use additional forms.

Section 6 – Survivor Authorization

❑ I have attached a personal check in the amount of $___ ___ ___ ___ . ___ ___ to pay for my first month's premium.

❑ I wish to be direct billed for my premiums.

❑ Please deduct my premiums from my survivor benefit check.

I hereby certify the above information is true and correct, and authorize the deduction necessary to pay for the coverage elected (if applicable).

Signature: ____________________

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

Revised: 12/2014