



Missouri Consolidated Health Care Plan
 PO Box 104355 • 832 Weathered Rock Court
 Jefferson City, MO 65110-4355
 Phone: 800-487-0771 • 573-751-0771
 Fax: 866-346-8785 • Web: www.mchcp.org

EXAMPLE
 Marriage — Adding Dependent(s)
 Before the Event

(Highway Patrol, MoDOT & Conservation)

M-2a Change/Cancellation

Please print in black or blue ink.

New Address:

SECTION 1	<input checked="" type="checkbox"/> CHANGE <input type="checkbox"/> Name <input type="checkbox"/> Address <input checked="" type="checkbox"/> ADD Coverage due to life event or loss of coverage <input type="checkbox"/> DROP Dependent—Reason & date of occurrence: <input type="radio"/> Divorce: _____ <input type="radio"/> Death: _____ <input type="radio"/> Emancipation: _____ <input type="radio"/> Other: _____	DENTAL Plan Code #: <div style="border: 1px solid black; padding: 2px; display: inline-block;">5 7</div> VISION Plan Code #: <div style="border: 1px solid black; padding: 2px; display: inline-block;"> </div>	<input type="checkbox"/> CANCEL INSURANCE <input type="checkbox"/> Delta Dental <input type="checkbox"/> Vision Service Plan Cancel reason: _____ _____ _____ _____
------------------	---	--	---

If enrolled in the Cafeteria Plan, premium will not change until approved by the Cafeteria Plan.

SECTION 1	Social Security Number: 123-45-6789	Name: (LAST) (FIRST) (MI) Doe Jane A.	
	Address: (MAILING) (CITY) (STATE) (ZIP CODE) P.O. Box 4444 Columbia MO 65201		
	Daytime Phone Number: (573) 909-9999	Alternate Phone Number: (573) 609-1111	E-mail Address: Jane.Doe@mo.gov
	Date of Birth (MM/DD/YYYY): 12/17/1972	Sex: <input type="checkbox"/> M <input checked="" type="checkbox"/> F	Marital Status: <input type="checkbox"/> SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED Date of Marriage: _____
	County Code Where You LIVE: <div style="border: 1px solid black; padding: 2px; display: inline-block;">0 1 0</div> County Name: Boone	County Code Where You WORK: <div style="border: 1px solid black; padding: 2px; display: inline-block;">0 2 6</div> County Name: Cole	

IMPORTANT: If adding a spouse or child, **no coverage is provided until proof of eligibility (POE) is received.** Refer to the Member Handbook or www.mchcp.org for details.

DENTAL Coverage Level (check one): Subscriber Subscriber/Spouse Subscriber/Child(ren) Subscriber/Family

VISION Coverage Level (check one): Subscriber Subscriber/Spouse Subscriber/Child(ren) Subscriber/Family

Subscriber and dependents to be enrolled, deleted, changed: (Use additional sheets for more dependents.)

SECTION 2	(E)nroll (D)elete (C)hange	Den(T)al (V)ision (A)ll	Subscriber/Dependent Social Security Number	Last Name	First Name	MI	Date of Birth (MM/DD/YYYY)	Sex M or F	Relation (Self, Spouse, Child)
	E	T	888-99-0000	Doe	Joseph	R.	10/20/1970	M	Spouse
When you receive your marriage license, marriage certificate, or newspaper notice of wedding, submit it to MCHCP. (Refer to Member Handbook for more details.)									

SECTION 3	If your spouse is currently employed by the State of Missouri or in a position in which they are eligible for insurance coverage through MCHCP, please complete the following information:	Employer: _____
	Spouse's Social Security Number: _____ Spouse's Full Name (LAST, FIRST, MI): _____	

SECTION 4	I hereby make the above designation(s) and authorize, if applicable, changes to established pre-tax deductions. I also hereby authorize the appropriate providers to release any documentation necessary to process my or my dependent's claims/benefits. I authorize my chosen health plan to provide MCHCP the information necessary to validate benefits received and payment of claims to which I am entitled under the MCHCP plan.	Effective date will be first of month in which the event occurred.	Effective Date (MM/DD/YYYY): <div style="border: 1px solid black; padding: 2px; display: inline-block;">1 0 0 1 2 0 0 9</div>
	Signature of Subscriber: <i>Jane A. Doe</i>	Date: 09/09/2009	