



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
 Name Change
 (Marriage, Divorce, Other)

(Highway Patrol, MoDOT & Conservation)

M-2a Change/Cancellation

Please print in black or blue ink.

New Address:

CHANGE Name Address

ADD Coverage due to life event or loss of coverage

DROP Dependent—Reason & date of occurrence:

Divorce: _____

Death: _____

Emancipation: _____

Other: Legal name change

DENTAL Plan Code #:

VISION Plan Code #:

CANCEL INSURANCE

Delta Dental 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) Doe (FIRST) Jane (MI) A.

Address: (MAILING) P.O. Box 4444 (CITY) Columbia (STATE) MO (ZIP CODE) 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: M F Marital Status: SINGLE MARRIED WIDOWED
 Date of Marriage: _____

County Code Where You LIVE: County Name: Boone County Code Where You WORK: 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)

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, coverage elected including changes to established pre-tax deduction. 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 following signature and receipt date. **Effective Date (MM/DD/YYYY):**

Signature of Subscriber: Jane A. Doe Date: 10/09/2009