



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

(Highway Patrol, MoDOT & Conservation)

EXAMPLE
 Retirement — Go to State Spouse's
 Coverage — Spouse Form

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 checked="" type="checkbox"/> Other: <u>Transfer coverage from SSN: 777-66-8888</u>	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;">9 9</div>	<input type="checkbox"/> CANCEL INSURANCE <input type="checkbox"/> Delta Dental <input type="checkbox"/> Vision Service Plan Cancel reason: _____ _____ _____ _____
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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): 01/01/1949	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 2 7</div> County Name: Cooper	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	TV	777-66-8888	Doe	John	S.	12/17/1949	M	Spouse
Include Spouse's M-5a Form. See previous example.									

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, the deduction(s) necessary to pay for the coverage elected including changes to established pre-tax deductions under the Missouri State Employees' Cafeteria Plan. 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 (MM/DD/YYYY): <div style="border: 1px solid black; padding: 2px; display: inline-block;">1 1 0 1 2 0 0 9</div>
	Signature of Subscriber: <i>Jane A. Doe</i>	Date: 10/03/2009