



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.mhcp.org

(Highway Patrol, MoDOT & Conservation)

EXAMPLE
 Terminate Employment — Non-Vested
 Cancel Coverage

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: _____

DENTAL Plan Code #: **5 7**

VISION Plan Code #: **9 9**

CANCEL INSURANCE

Delta Dental Vision Service Plan

Cancel reason: Ending Employment

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

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: **0 2 7** County Name: **Cooper** County Code Where You WORK: **0 2 6** 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.mhcp.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.)

(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)
D	TV	123-45-6789	Doe	Jane	A.	12/17/1972	F	Self

COBRA paperwork will be mailed to employee home address.
****Completion of this form is optional****

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: **Department of Revenue**

Spouse's Social Security Number: **888-99-0000** Spouse's Full Name (LAST, FIRST, MI): **Doe, Joseph R.**

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.

Signature of Subscriber: *Jane A. Doe* Effective Date (MM/DD/YYYY): **0 6 3 0 2 0 0 9**

Date: **06/20/2009**