



**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**  
 Terminate Employment— Non-Vested  
 Go to State Spouse's Coverage — Spouse Form

(Highway Patrol, MoDOT & Conservation)

## M-2a Change/Cancellation

Please print in black or blue ink.

New Address:

<input checked="" type="checkbox"/> <b>CHANGE</b> <input type="checkbox"/> Name <input type="checkbox"/> Address  <input checked="" type="checkbox"/> <b>ADD</b> Coverage due to life event or loss of coverage <input type="checkbox"/> <b>DROP</b> 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: 123-45-6789</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"/> <b>CANCEL INSURANCE</b> <input type="checkbox"/> Delta Dental <input type="checkbox"/> Vision Service Plan Cancel reason: _____ _____ _____ _____
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<b>If enrolled in the Cafeteria Plan, premium will not change until approved by the Cafeteria Plan.</b>			
Social Security Number: <b>888-99-0000</b>	Name: (LAST) (FIRST) (MI) <b>Doe John S.</b>		
Address: (MAILING) (CITY) (STATE) (ZIP CODE) <b>12576 Any Street Columbia MO 65201</b>			
Daytime Phone Number: <b>( 573 ) 909-2222</b>	Alternate Phone Number: <b>( 573 ) 609-1222</b>	E-mail Address: <b>John.Doe@mo.gov</b>	
Date of Birth (MM/DD/YYYY): <b>10/08/1969</b>	Sex: <input checked="" type="checkbox"/> M <input 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: <b>Cooper</b>		County Code Where You WORK: <div style="border: 1px solid black; padding: 2px; display: inline-block;">0 2 6</div> County Name: <b>Cole</b>	

**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):	<input type="checkbox"/> Subscriber	<input checked="" type="checkbox"/> Subscriber/Spouse	<input type="checkbox"/> Subscriber/Child(ren)	<input type="checkbox"/> Subscriber/Family
VISION Coverage Level (check one):	<input type="checkbox"/> Subscriber	<input checked="" type="checkbox"/> Subscriber/Spouse	<input type="checkbox"/> Subscriber/Child(ren)	<input type="checkbox"/> 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	Spouse
<div style="border: 1px solid black; padding: 5px; display: inline-block;"> <b>Include Spouse's M-2a Form. See previous example.</b>  <b>**Attaching Spouse's M-2a form is optional**</b> </div>								

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):

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;">0 7 0 1 2 0 0 9</div>
Signature of Subscriber: <i>John S. Doe</i>	Date: <b>06/20/2009</b>