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
Retirement — Terminate Coverage

(Highway Patrol, MoDOT & Conservation)

M-3a Continuation of Coverage During Leave

Please **print** in black or blue ink.

New Address: ☐

SECTION 1

Social Security Number:	Name: (LAST)	(FIRST)	(MI)
777-66-8888		John	S.

Be sure to use HOME phone number, *not* current work number.

Address: (MAILING)	(CITY)	(STATE)	(ZIP CODE)
12576 Any Street	Columbia	MO	65201

Daytime Phone Number:	Alternate Phone Number:	Email Address:
(573) 609-1222	(573) 909-2222	015John.Doe@mo.gov

Date of Birth (MM/DD/YYYY): 12/17/1972 Sex: ☑ M ☐ F Marital Status: ☐ SINGLE ☑ MARRIED ☐ WIDOWED

County Code Where You LIVE: 0 1 0 *County Name:* Boone

County Code Where You WORK: 0 2 6 *County Name:* Camden

SECTION 2

EMPLOYEE COMPLETES WHEN GOING ON A LEAVE STATUS—During the period of time I am on leave of absence status:

☐ I wish to continue the following coverage and be billed monthly for the required premium. ☑ I elect NO COVERAGE

(**Note:** You cannot terminate dental and vision coverage without also terminating medical coverage.)

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 t

COBRA paperwork will be mailed to employee home address.

PLEASE NOTE: If you cancel coverage, you will *not* be able to re-enroll in the future, *not* even with a loss of other coverage.

(D)elete (C)hange	Den(T)al (V)ision (A)ll	Subscriber/Dependent Social Security Number		Birth /YYYY)	Sex M or F	Relation (Self, Spouse, Child)

Signature of Subscriber: *John S. Doe*

Date: 10/03/2009