



**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**  
 Survivor — Retain Coverage

(Highway Patrol, MoDOT & Conservation)

## M-7a Application for Survivor to Retain Coverage

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

New Address:

<b>SECTION 1</b>	Social Security Number: <b>888-99-0000</b>		Name: (LAST) <b>Doe</b>		(FIRST) <b>Joseph</b>		(MI) <b>R.</b>
	Address: (MAILING) <b>P.O. Box 444</b>		(CITY) <b>Columbia</b>		(STATE) <b>MO</b>	(ZIP CODE) <b>65201</b>	
	Sex: <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Marital Status: <input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input checked="" type="checkbox"/> WIDOWED		Date of Birth (MM/DD/YYYY):			
	Daytime Phone Number: <b>( 573 ) 609-1111</b>		Alternate Phone Number: <b>( 573 ) 609-2244</b>		Email Address: <b>Joseph.Doe@mo.gov</b>		

<b>SECTION 2</b>	<b>Deceased Member Information</b>						
	Date of Death (MM/DD/YYYY): <b>11/22/2009</b>	Social Security Number: <b>123-45-6789</b>		Name: (LAST) <b>Doe</b>		(FIRST) <b>Jane</b>	(MI) <b>A.</b>

**IMPORTANT:** If adding a spouse or child, **no coverage is provided until proof of eligibility is received.** Refer to the Member Handbook or [www.mchcp.org](http://www.mchcp.org) for details.

I elect **NO Coverage** (Skip to Section 4)

I elect **Dental Coverage**

I elect **Vision Coverage**

Level of Coverage (check one):  Subscriber  Subscriber/Child(ren)  Child(ren)

**Complete section below for coverage:**

Enroll/Continue	Social Security Number	Last Name	First Name	MI	Date of Birth (MM/DD/YYYY)	Sex M or F	Relation (Self, Child)
<b>E</b>	<b>888-99-0000</b>	<b>Doe</b>	<b>Joseph</b>	<b>R.</b>	<b>10/20/1970</b>	<b>M</b>	<b>Self</b>
<b>E</b>	<b>231-56-7890</b>	<b>Doe</b>	<b>Jonathan</b>	<b>C.</b>	<b>02/20/2000</b>	<b>M</b>	<b>Child</b>
<b>E</b>	<b>330-00-2222</b>	<b>Doe</b>	<b>Josie</b>	<b>D.</b>	<b>10/07/2006</b>	<b>F</b>	<b>Child</b>

Check  appropriate selection here.

I have attached a personal check in the amount of \$ \_\_\_\_\_ to pay for my \_\_\_\_\_ Month coverage.

I wish to be direct billed for my coverage.

Please deduct the payment for my coverage out of my survivor benefit check.

<b>SECTION 4</b>	I hereby certify the above information is true and correct and authorize the deduction necessary to pay for the coverage elected (if applicable).	
	Signature of Survivor: <i>Joseph R. Doe</i>	Date: <b>11/28/2009</b>