



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
 Vested — Add Coverage

(Highway Patrol, Mouri & Conservation)

M-8a Vested Enrollment Form

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

New Address:

SECTION 1	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	Email Address: Jane.Doe@mo.gov
	Alternate Phone Number: (573) 609-1111	County Code Where You LIVE: 0 2 7 County Name: Cooper

SECTION 2

Check all that apply: (If adding coverage, attach proof of prior coverage.)

CONTINUE dental coverage
 CONTINUE vision coverage
 TRANSFER coverage to spouse's SSN:
 TERMINATE dental coverage
 TERMINATE vision coverage
 ADD dental coverage
 ADD vision coverage

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 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

SECTION 3

Complete section below for all dependents to be covered:

Enroll/Continue	Subscriber/Dependent Social Security Number	Last Name	First Name	MI	Date of Birth (MM/DD/YYYY)	Sex M or F	Relation (Self, Spouse, Child)

**Attach certificate of Prior Coverage
 (See Proof-of-Insurance definition in Member Handbook.)
 Attach Proof-of-Eligibility documentation if enrolling dependents.**

SECTION 4

Please send this completed form directly to MCHCP:

Fax - 866-346-8785
 **Mail - PO Box 104355
 Jefferson City, MO 65110-4355**

I hereby request enrollment in MCHCP for myself and eligible qualified dependents listed on this form and agree to pay the premium as required. I understand that full payment (the amount specified in the letter) must be submitted with this form or within 45 days of MCHCP's receipt of this form. I also acknowledge that I will be billed for the premium each month and that failure to pay future billing will result in termination of coverage.

Signature of Subscriber: *Jane A. Doe* **Date:** **06/20/2009**