



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
 Adding Child(ren) — Before the Event
 Adoption, Birth, Legal Custody, Guardianship of Minor

M-2 Change/Cancellation

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

New Address:

SECTION 1	<input checked="" type="checkbox"/> CHANGE <input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Plan <input checked="" type="checkbox"/> ADD Coverage due to life event or loss of coverage <input type="checkbox"/> DROP Dependent—Reason & date of occurrence: <input type="radio"/> Divorce: _____ <input type="radio"/> Death: _____ <input type="radio"/> Emancipation: _____ <input type="radio"/> Other: _____	MEDICAL Plan Code #: 9 1 DENTAL Plan Code #: <input type="text"/> VISION Plan Code #: <input type="text"/>	<input type="checkbox"/> CANCEL INSURANCE <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION Cancel reason: _____ _____ _____
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If enrolled in the Cafeteria Plan, premium will not change until approved by the Cafeteria Plan.

SECTION 1	Social Security Number: 123-45-6789	Name: (LAST) (FIRST) (MI) Doe Jane A.
	Address: (MAILING) (CITY) (STATE) (ZIP CODE) P.O. Box 4444 Columbia MO 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: <input type="checkbox"/> M <input checked="" 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: 0 1 0 County Name: Boone	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.mchcp.org for details. POE Previously Provided

SECTION 2	MEDICAL Coverage Level (check one): <input type="checkbox"/> Subscriber <input type="checkbox"/> Subscriber/Spouse <input checked="" type="checkbox"/> Subscriber/Child(ren) <input type="checkbox"/> Subscriber/Family
	DENTAL Coverage Level (check one): <input type="checkbox"/> Subscriber <input 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 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	(M)edical 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)	PCP # (Mercy Southwest & South Central Only) Refer to Plan Directory
E	M	Unknown	Doe	"Baby"		10/07/2006 (Due Date)	?	Child	

If Subscriber only wants 31 days of free coverage for a newborn, please make a note on the form "FREE Coverage Only". MCHCP must be notified within 31 days of baby's birth. When Social Security Number is received, submit new change form (M-2) and copy of card.

Attach Proof-of-Eligibility (Refer to Member Handbook for more details.)

SECTION 3	If your spouse has insurance coverage through MCHCP, please complete the following information:
	Spouse's Social Security Number: _____ Spouse's Full Name (LAST, FIRST, MI): _____

Effective date will be first of month following signature and receipt date, except in case of birth or adoption (first of month of date of birth or placement becomes the effective date).

SECTION 4	I hereby make the above coverage elected including _____ Plan. I also hereby authorize 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): 1 0 0 1 2 0 0 9
	Signature of Subscriber: <i>Jane A. Doe</i>	Date: 10/21/2009