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
Marriage — Add Dependent(s) After the Event

M-2 Change/Cancellation

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

New Address: ☐

SECTION 1

☑ **CHANGE** ☐ Name ☐ Address ☐ Plan

☑ **ADD** Coverage due to life event or loss of coverage

☐ **DROP** Dependent—*Reason & date of occurrence:*

- ○ *Divorce:* ____
- ○ *Death:* ____
- ○ *Emancipation:* ____
- ○ *Other:* ____

MEDICAL Plan Code #: 9 1

DENTAL Plan Code #: ____

VISION Plan Code #: ____

☐ **CANCEL INSURANCE**

☐ MEDICAL ☐ DENTAL ☐ VISION

Cancel reason: ____

If enrolled in the Cafeteria Plan, premium will not change until approved by the Cafeteria Plan.

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

Alternate Phone Number: (573) 609-1111

E-mail Address: Jane.Doe@mo.gov

Date of Birth (MM/DD/YYYY): 12/17/1972

Sex: ☐ M ☑ F

Marital Status: ☐ SINGLE ☑ MARRIED ☐ WIDOWED

Date of Marriage:

County Code Where You LIVE: 0 2 6 *County Name:* Cole

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

SECTION 2

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

MEDICAL Coverage Level (check one): ☐ Subscriber ☑ Subscriber/Spouse ☐ Subscriber/Child(ren) ☐ Subscriber/Family

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 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	MV	888-99-0000	Doe	John	R.	10/20/1970	M	Spouse	

When you receive your marriage license, marriage certificate, or newspaper notice of wedding, submit it to MCHCP. (Refer to Member Handbook for more details.)

SECTION 3

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):

SECTION 4

I hereby make the above designation(s) and authorize, if applica[ble] ... coverage elected including changes to established pre-tax dedu[ctions] ... [Cafeter]ia 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 will be first of month following signature and receipt date.

Effective Date (MM/DD/YYYY): 1 1 0 1 2 0 0 9

Signature of Subscriber: *Jane A. Doe*

Date: 10/09/2009