



**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 — Adding Dependent(s)  
 Before the Event

**M-2 Change/Cancellation**

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

New Address:

<b>SECTION 1</b>	<input checked="" type="checkbox"/> <b>CHANGE</b> <input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Plan <input checked="" type="checkbox"/> <b>ADD</b> Coverage due to life event or loss of coverage <input type="checkbox"/> <b>DROP</b> Dependent—Reason & date of occurrence: <input type="radio"/> Divorce: _____ <input type="radio"/> Death: _____ <input type="radio"/> Emancipation: _____ <input type="radio"/> Other: _____	MEDICAL Plan Code #: <b>9 1</b> DENTAL Plan Code #: <input type="text"/> VISION Plan Code #: <input type="text"/>	<input type="checkbox"/> <b>CANCEL INSURANCE</b> <input type="checkbox"/> MEDICAL <input type="checkbox"/> DENTAL <input type="checkbox"/> VISION Cancel reason: _____ _____ _____
------------------	---	---	--

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

<b>SECTION 1</b>	Social Security Number: <b>123-45-6789</b>	Name: (LAST) (FIRST) (MI) <b>Doe Jane A.</b>
	Address: (MAILING) (CITY) (STATE) (ZIP CODE) <b>P.O. Box 4444 Columbia MO 65201</b>	
	Daytime Phone Number: <b>( 573 ) 909-9999</b>	Alternate Phone Number: <b>( 573 ) 609-1111</b>
	E-mail Address: <b>Jane.Doe@mo.gov</b>	
	Date of Birth (MM/DD/YYYY): <b>12/17/1972</b> 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: <b>0 1 0</b> County Name: <b>Boone</b>	County Code Where You WORK: <b>0 2 6</b> County Name: <b>Cole</b>	

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

<b>SECTION 2</b>	<b>MEDICAL</b> Coverage Level (check one): <input type="checkbox"/> Subscriber <input checked="" type="checkbox"/> Subscriber/Spouse <input type="checkbox"/> Subscriber/Child(ren) <input type="checkbox"/> Subscriber/Family
	<b>DENTAL</b> Coverage Level (check one): <input type="checkbox"/> Subscriber <input type="checkbox"/> Subscriber/Spouse <input type="checkbox"/> Subscriber/Child(ren) <input type="checkbox"/> Subscriber/Family
	<b>VISION</b> 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 (D)ental (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
<b>E</b>	<b>M</b>	<b>888-99-0000</b>	<b>Doe</b>	<b>Joseph</b>	<b>R.</b>	<b>10/20/1970</b>	<b>M</b>	<b>Spouse</b>	
<b>When you receive your marriage license, marriage certificate, or newspaper notice of wedding, submit it to MCHCP. (Refer to Member Handbook for more details.)</b>									

<b>SECTION 3</b>	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): _____

<b>SECTION 4</b>	I hereby make the above designation(s) and authorize, if applicable, coverage elected including changes to established pre-tax deductions. 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 in which the event occurred.	Effective Date (MM/DD/YYYY): <b>1 0 0 1 2 0 0 9</b>
	Signature of Subscriber: <i>Jane A. Doe</i>		Date: <b>09/09/2009</b>