



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
 Leave of Absence — Continue Coverage

M-3 Continuation of Coverage During Leave

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		Alternate Phone Number: (573) 609-1111		Email 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			
	County Code Where You LIVE: 0 1 0 County Name: Boone				County Code Where You WORK: 0 2 6 County Name: Cole				

SECTION 2	EMPLOYEE COMPLETES WHEN GOING ON A LEAVE STATUS—During the period of time I am on leave of absence status:																																																																																							
	<input checked="" type="checkbox"/> I wish to continue the following coverage and be billed monthly for the required premium. <input type="checkbox"/> I elect NO COVERAGE (Note: You cannot terminate dental and vision coverage without also terminating medical coverage.)																																																																																							
	MEDICAL Coverage Level (check one): <input checked="" type="checkbox"/> Subscriber <input type="checkbox"/> Subscriber/Spouse <input type="checkbox"/> Subscriber/Child(ren) <input type="checkbox"/> Subscriber/Family																																																																																							
	DENTAL Coverage Level (check one): <input checked="" 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 checked="" type="checkbox"/> Subscriber <input type="checkbox"/> Subscriber/Spouse <input type="checkbox"/> Subscriber/Child(ren) <input type="checkbox"/> Subscriber/Family																																																																																							
	Subscriber and dependents to be deleted or changed:																																																																																							
	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 5%;">(D)delete (C)hange</th> <th style="width: 5%;">(M)edical (D)ental (V)ision (A)ll</th> <th style="width: 15%;">Subscriber/Dependent Social Security Number</th> <th style="width: 15%;">Last Name</th> <th style="width: 15%;">First Name</th> <th style="width: 5%;">MI</th> <th style="width: 10%;">Date of Birth (MM/DD/YYYY)</th> <th style="width: 5%;">Sex M or F</th> <th style="width: 10%;">Relation (Self, Spouse, Child)</th> <th style="width: 10%;">PCP # (Mercy Southwest & South Central Only) Refer to Plan Directory</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>								(D)delete (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																																																																						
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Signature of Subscriber: <i>Jane A. Doe</i>						Date: 07/21/2009																																																																																		