



**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 — Continue Coverage

**M-8 Vested Enrollment Form**

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

New Address:

<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</b> ) <b>909-9999</b>	Email Address: <b>Jane.Doe@mo.gov</b>
	Alternate Phone Number: ( <b>573</b> ) <b>609-1111</b>	County Code Where You LIVE: <b>0 2 7</b> County Name: <b>Cooper</b>

<b>SECTION 2</b>	*If you are enrolled in the county where you WORK, you must elect a plan available in the county where you LIVE. If you are required to change plans, please complete the following:  * Medical Plan Code Number: <input type="text"/>	Check all that apply: (If adding coverage, attach proof of prior coverage.) <input checked="" type="checkbox"/> CONTINUE medical coverage <input checked="" type="checkbox"/> CONTINUE dental coverage <input checked="" type="checkbox"/> CONTINUE vision coverage <input type="checkbox"/> TERMINATE medical coverage <input type="checkbox"/> TERMINATE dental coverage <input type="checkbox"/> TERMINATE vision coverage <input type="checkbox"/> ADD medical coverage <input type="checkbox"/> ADD dental coverage <input type="checkbox"/> ADD vision coverage  <input type="checkbox"/> TRANSFER coverage to spouse's SSN: _____
------------------	--	---

<b>SECTION 3</b>	<b>IMPORTANT:</b> If adding a spouse or child, <b>no coverage is provided until proof of eligibility is received.</b> Refer to the Member Handbook or www.mchcp.org for details.
	<b>MEDICAL</b> 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
	<b>DENTAL</b> 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
	<b>VISION</b> 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
	If spouse is employed by the State of Missouri, complete the following: Spouse's Name: <b>John Doe</b> Spouse's SSN: <b>777-66-8888</b>
	Are you or any dependents covered by Medicare? <input type="checkbox"/> YES <input type="checkbox"/> NO    NOTE: Attach copies of all Medicare card(s).

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)	PCP # (Mercy Southwest & South Central Only) Refer to Plan Directory

<b>SECTION 4</b>	Please send this completed form directly to MCHCP:  <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> <b>Fax - 866-346-8785</b></div> <div style="text-align: center;"> <b>Mail - PO Box 104355 Jefferson City, MO 65110-4355</b></div> </div>
------------------	--

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: <i>Jane A. Doe</i>	Date: <b>06/20/2009</b>
--	----------------------------