Missouri Consolidated Health Care Plan

Leave of Absence Enrollment

Highway Patrol, MoDOT, & Conservation
Dental & Vision Only

Submit this form
Online: Upload through myMCHCP
Fax: 866-346-8785
Mail: PO Box 104355
Jefferson City, MO 65110-4355

ST LOAE

Revised 04/2024

Section 1: Subscriber Information

Please print carefully.

Name (Last, First, MI): ☐ New Name

MCHCP ID: -

OR

Social Security Number: - -

Address: ☐ New Address

City: **State**: **Zip Code**: **Date of Birth** (MM/DD/YYYY): / /

Email Address: **County Where You Live**: **Primary Phone**: ☐Home ☐Work ☐Cell ( ) -

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed

Date of Marriage (MM/DD/YYYY): / /

Secondary Phone: ☐Home ☐Work ☐Cell ( ) -

Section 2: Continue, Cancel, or Transfer Coverage

☐ **Continue Coverage**:
- ☐ Dental
- ☐ Vision

☐ **Cancel Coverage**:
- ☐ Dental
- ☐ Vision

☐ **Transfer** to my spouse's MCHCP coverage
(Spouse should submit an Enroll/Change/Cancel form to enroll you.)

Spouse's Name (Last, First, MI):

Spouse's Social Security Number: - -

Section 3: Coverage Levels

Dental

☐ S ☐ S/S ☐ S/C ☐ S/F

Vision

☐ S ☐ S/S ☐ S/C ☐ S/F

Coverage Levels: *S - Subscriber Only* *S/S - Subscriber & Spouse* *S/C - Subscriber & Children* *S/F - Subscriber & Family*

Section 4: Dependents to be Enrolled, Changed, or Canceled

Action: *E - Enroll C - Change D - Cancel* **Relation**: *S - Spouse C: Child O: Other (Stepchild, Grandchild, etc)* **Coverage**: *D - Dental V - Vision*
If adding a spouse or child, no coverage is provided until proof of eligibility is received. See www.mchcp.org for details. Use additional forms for more space.

Action	Social Security Number:	Name (Last, First, MI):	Date of Birth (MM/DD/YYYY):	Relation:	Gender:	Coverage:
☐E ☐C ☐D	- -		/ /	☐S ☐C ☐O	☐M ☐F	☐D ☐V
☐E ☐C ☐D	- -		/ /	☐S ☐C ☐O	☐M ☐F	☐D ☐V
☐E ☐C ☐D	- -		/ /	☐S ☐C ☐O	☐M ☐F	☐D ☐V
☐E ☐C ☐D	- -		/ /	☐S ☐C ☐O	☐M ☐F	☐D ☐V
☐E ☐C ☐D	- -		/ /	☐S ☐C ☐O	☐M ☐F	☐D ☐V
☐E ☐C ☐D	- -		/ /	☐S ☐C ☐O	☐M ☐F	☐D ☐V

Section 5: Subscriber Authorization

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 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:

Date (MM/DD/YYYY): / /