



Missouri Consolidated Health Care Plan
Leave of Absence Enrollment

State Members

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



Revised 10/2021

Section 1: Subscriber Information Please print carefully.

Name (Last, First, MI): [] New Name
Address: [] New Address
City: State: Zip Code:
Email Address: County Where You Live:
Gender: Marital Status: Date of Marriage (MM/DD/YYYY):
[] Male [] Female [] Single [] Married [] Widowed

MCHCP ID:
OR
Social Security Number:
Date of Birth (MM/DD/YYYY):
Primary Phone: [] Home [] Work [] Cell
Secondary Phone: [] Home [] Work [] Cell

Section 2: Continue, Cancel, or Transfer Coverage

[] Continue Coverage: [] Cancel Coverage: [] Transfer to my spouse's MCHCP coverage
[] Medical [] Dental [] Vision
[] Medical [] Dental [] Vision
Spouse's Name (Last, First, MI):
Spouse's Social Security Number:

Section 3: Coverage Levels

Medical: [] S [] S/S [] S/C [] S/F
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

Table with columns: Action, Social Security Number, Name (Last, First, MI), Date of Birth (MM/DD/YYYY), Relation, Gender, Coverage. Includes instructions for adding dependents.

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):