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Missouri Consolidated Health Care Plan
573-751-0771 · 800-487-0771 · www.mchcp.org
832 Weathered Rock Court, Jefferson City, MO 65101

Leave of Absence Enrollment

State Members

Please complete this form to indicate coverage selections during leave of absence

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

MCHCP Use Only

ST LOAE

Please print clearly

Section 1 – Subscriber Information

Name (Last, First, Middle Initial): ☐ New Name

MCHCPid (Provide **either** MCHCPid or Social Security Number)
___ ___ ___ ___ ___ – ___ ___ ___ ___ ___

Address: ☐ New Address

or **Social Security Number**:
___ ___ ___– ___ ___– ___ ___ ___ ___

City: **State**: **ZIP Code**:

Date of Birth (MM/DD/YYYY):
___ ___/ ___ ___/ ___ ___ ___ ___

Email:

County Where You Live:

Primary Phone Number: ☐ Home ☐ Work ☐ Mobile
(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Widowed

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

Secondary Phone Number: ☐ Home ☐ Work ☐ Mobile
(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

Section 2 – Continue, Cancel or Transfer Coverage

☐ **Continue Coverage**
- ☐ Medical
- ☐ Dental
- ☐ Vision

☐ **Cancel Coverage**
- ☐ Medical
- ☐ 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, Middle Initial):

Spouse's Social Security Number:
___ ___ ___– ___ ___– ___ ___ ___ ___

Section 3 – Level of Coverage Selections

Medical	Dental	Vision
☐ Subscriber Only	☐ Subscriber Only	☐ Subscriber Only
☐ Subscriber/Spouse	☐ Subscriber/Spouse	☐ Subscriber/Spouse
☐ Subscriber/Child(ren)	☐ Subscriber/Child(ren)	☐ Subscriber/Child(ren)
☐ Subscriber/Family	☐ Subscriber/Family	☐ Subscriber/Family

Medical plan premiums include one child. Premiums increase based on each additional child up to five. Refer to the Benefit Guide packet or www.mchcp.org for details.

Section 4 – Dependents to be Changed or Cancelled

Action – **C:** Change **D:** Cancel **Relationship** – **S:** Spouse **C:** Child **O:** Other (Stepchild, Grandchild, etc.) **Coverage** – **M:** Medical **D:** Dental **V:** Vision

Action (Circle)	Social Security Number	Name (Last, First, Middle Initial)	Date of Birth (MM/DD/YYYY)	Relationship (Circle)	Gender (Circle)	Coverage (Circle)
C D	___ ___ ___– ___ ___– ___ ___ ___ ___		___ ___/ ___ ___/ ___ ___ ___ ___	S C O	M F	M D V
C D	___ ___ ___– ___ ___– ___ ___ ___ ___		___ ___/ ___ ___/ ___ ___ ___ ___	S C O	M F	M D V
C D	___ ___ ___– ___ ___– ___ ___ ___ ___		___ ___/ ___ ___/ ___ ___ ___ ___	S C O	M F	M D V
C D	___ ___ ___– ___ ___– ___ ___ ___ ___		___ ___/ ___ ___/ ___ ___ ___ ___	S C O	M F	M D V
C D	___ ___ ___– ___ ___– ___ ___ ___ ___		___ ___/ ___ ___/ ___ ___ ___ ___	S C O	M F	M D V

If more space is needed, please use additional forms.

Section 5 – Subscriber Authorization

I hereby make the above designation(s) and understand I will be billed monthly for the coverage elected.

Signature:

Date (MM/DD/YYYY):
___ ___/ ___ ___/ ___ ___ ___ ___