



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



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

Leave of Absence Enrollment

State Members – Dental and Vision Only

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

Gender: Male Female **Marital Status:** Single Married Widowed **Date of Marriage** (MM/DD/YYYY): **Secondary Phone Number:** Home Work Cell

Section 2 – Continue, Cancel or Transfer Coverage

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

Dental Dental **Spouse's Name** (Last, First, Middle Initial):

Vision Vision **Spouse's Social Security Number:**

Section 3 – Level of Coverage Selections

Dental	Vision
<input type="checkbox"/> Subscriber Only	<input type="checkbox"/> Subscriber Only
<input type="checkbox"/> Subscriber/Spouse	<input type="checkbox"/> Subscriber/Spouse
<input type="checkbox"/> Subscriber/Child(ren)	<input type="checkbox"/> Subscriber/Child(ren)
<input type="checkbox"/> Subscriber/Family	<input type="checkbox"/> Subscriber/Family

Section 4 – Subscriber and Dependents to be Changed or Cancelled

Action – C: Change **D:** Cancel **Relationship – S:** Spouse **C:** Child **O:** Other (Stepchild, Grandchild, etc.) **Coverage – 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	D V
C D	_____	_____	___/___/_____	S C O	M F	D V
C D	_____	_____	___/___/_____	S C O	M F	D V
C D	_____	_____	___/___/_____	S C O	M F	D V
C D	_____	_____	___/___/_____	S C O	M F	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): _____