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 10/2021*

## 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): / /