MercyCare Health Plans

MercyCare Health Plans
MercyCare HMO, Inc.
PO Box 550
Janesville, WI 53547
(800) 895-2421 • (877) 908-6027
mercycarehealthplans.com

Employee is choosing the following plan option: (Name of Plan) _____

ENROLLMENT APPLICATION

(Please print or type)

EMPLOYEE INFORMATION

Employee Last Name _____ Employee First Name _____ Middle Initial _____

Social Security Number (required) _____ Employee's Birthday (MM/DD/YYYY) _____

Home Address _____ ☐ Female ☐ Male

City _____ State _____ Zip Code _____ County _____

Employee's Home Telephone _____ Work Phone _____

Employer and Location _____

Application for Health Coverage (Check One)

- ☐ **Employee Only**
- ☐ **Employee & Spouse**
- ☐ **Employee +1**
- ☐ **Employee/Child(ren)**
- ☐ **Family**
- ☐ **None/Declined** (complete "Other Health Insurance" section below)

Current Marital Status (Check One)

- ☐ **Single**
- ☐ **Married**
- ☐ **Widowed**
- ☐ **Divorced**
- ☐ **Separated**

OTHER HEALTH INSURANCE INFORMATION

1. Will any family members, including those not listed below, be covered by other health insurance or Medicare? If yes, fill out this section. Use extra paper if more than one additional policy is in force. ☐ No ☐ Yes
   Coverage Type: ☐ Medical Insurance ☐ Medicare
2. Insurance Company Name _____
3. Phone Number (with area code) _____
4. Policy Number _____
5. Policy Coverage Dates _____ to _____
6. Name of Policyholder _____
7. Policyholder's Birthdate _____
8. Family Member's Covered _____
9. Policyholder's Employer Name _____
10. Employer Address _____
11. Employer Phone Number (with area code) _____
12. Name of Family Members Covered by Medicare _____
13. Medicare Claim Number _____
14. Medicare Part A Effective Date _____ Medicare Part B Effective Date _____
15. Is Medicare eligibility due ☐ Kidney Failure ☐ Disability
16. Are any of your dependents employed? ☐ Yes ☐ No
    If yes: Name of Employer _____ Phone _____
    Address _____

17. Do any of your eligible dependents have health insurance through their employer? ☐ Yes ☐ No

If yes: Name of Dependent _____

Name of Insurance Company _____

Address of Insurance Company _____

Contract Number _____

Type of Coverage: ☐ Single ☐ Family

Eligible Applicants Last Name/First Name	MI	Social Security # **(REQUIRED)**	Birth Date	Sex	Name of Physician	Currently a patient?
Employee						Y/N
Spouse						Y/N
Child						Y/N
Child						Y/N
Child						Y/N
Child						Y/N
Child						Y/N

I certify that I have read the statements in this application or that they have been read to me, and that they are, to the best of my knowledge and belief, true and complete. I understand and agree that my statements will be the basis for my coverage issued; that any material misrepresentation in this application that is relied on by MercyCare Insurance Company or MercyCare HMO, Inc. or both (Company) may be used to reduce or deny a claim or void the coverage; that no agent has the authority to waive a complete answer to any question, pass on insurability, make or alter any contract, or waive any of the Company's other rights or requirements; and that no coverage is effective until the date specified by the Company on a Certificate of Coverage. As may be required, I hereby authorize deduction for this coverage from my pay. The deductions shall continue until such authorization is revoked in accordance with the employer's policies and procedures.

PRINT NAME _____ DATE _____

EMPLOYEE SIGNATURE _____ DATE _____

SPOUSE SIGNATURE _____ DATE _____

DEPENDENT SIGNATURE (If over 18 years) _____ DATE _____

EMPLOYER MUST COMPLETE THE FOLLOWING:

Full-time Date of Hire (Month/Date/Year) _____

Coverage Effective Date _____

Group Number _____

Authorized Signature **(REQUIRED)** _____

Reason for Enrollment (Check One)

- ☐ Open Enrollment (If Applicable)
- ☐ New Hire
- ☐ Loss of Other Coverage (Certificate of Credible Coverage)
- ☐ Late Applicant
- ☐ Rehire Date _____
- ☐ Return From Layoff Date _____
- ☐ Part-Time to Full-Time Status Date _____
- ☐ Other Qualifying Event _____