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

Individual Direct Enrollment Request Form

Office Use Only: _____
Name of staff member/agent/broker (if assisted in enrollment): _____
Staff member/agent/broker NPN: _____
Effective Date of Coverage: _____
OEP: _____ SEP (type): _____ Not Eligible: _____

Please contact MercyCare Health Plans if you need information in another language or format.

To enroll in MercyCare Individual Plans please provide the following information:

Please check which plan you want to enroll in:

☐ MercyCare Gold Plan	☐ Option A	☐ Option B	☐ Option C	
☐ MercyCare Silver Plan	☐ Option A	☐ Option B	☐ Option C	
☐ MercyCare Bronze Plan	☐ Option A	☐ Option B	☐ Option C	☐ Option D

Step 1: Tell us about yourself.

LAST Name:	FIRST Name:	Middle Initial	☐ Mr. ☐ Mrs. ☐ Ms ☐ Miss

Birth Date: (___/___/_____) (M M / D D / Y Y Y Y)	Sex: ☐M ☐F	Home Phone Number: ( )	Alternate Phone Number: ( )

Permanent Residence Street Address: (Must reside in either Rock or Walworth County to be eligible)

City:	County:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):

Address: City: State: ZIP Code:

Email Address: _____

Social Security Number

_____-_____-_____

Do You Use Tobacco? (required if age 18 or older) ☐ Yes ☐ No
(Tobacco use is defined as use of tobacco on average of four or more times per week in past six months)

Does anyone applying for coverage currently have health insurance? ☐ Yes ☐ No
If Yes please fill in your insurance information below:
Current Insurance Provider: _____
Insurance Provider's Phone #: _____
Member ID Number(s): _____

Tell us who else needs health coverage on next page.

Step 2: Tell us about anyone else who needs health coverage.
(If you have more people to include, make a copy of this page and attach.)

Person 2

LAST Name:	FIRST Name:	Middle Initial	Relationship to you: ☐ Spouse/Domestic Partner ☐ Dependent ☐ Other_____
Birth Date: (___/___/_____) (M M / D D / Y Y Y Y)	Sex: ☐M ☐F	Social Security Number: _____-____-_____	

Does Person 2 live at the same address as you? ☐ Yes ☐ No **If no**, list address below.

Does Person 2 use tobacco? (required if age 18 or older) ☐ Yes ☐ No

Person 3

LAST Name:	FIRST Name:	Middle Initial	Relationship to you: ☐ Spouse/Domestic Partner ☐ Dependent ☐ Other_____
Birth Date: (___/___/_____) (M M / D D / Y Y Y Y)	Sex: ☐M ☐F	Social Security Number: _____-____-_____	

Does Person 3 live at the same address as you? ☐ Yes ☐ No **If no**, list address below.

Does Person 3 use tobacco? (required if age 18 or older) ☐ Yes ☐ No

Person 4

LAST Name:	FIRST Name:	Middle Initial	Relationship to you: ☐ Spouse/Domestic Partner ☐ Dependent ☐ Other_____
Birth Date: (___/___/_____) (M M / D D / Y Y Y Y)	Sex: ☐M ☐F	Social Security Number: _____-____-_____	

Does Person 4 live at the same address as you? ☐ Yes ☐ No **If no**, list address below.

Does Person 4 use tobacco? (required if age 18 or older) ☐ Yes ☐ No

Person 5

LAST Name:	FIRST Name:	Middle Initial	Relationship to you: ☐ Spouse/Domestic Partner ☐ Dependent ☐ Other_____
Birth Date: (___/___/_____) (M M / D D / Y Y Y Y)	Sex: ☐M ☐F	Social Security Number: _____-____-_____	

Does Person 5 live at the same address as you? ☐ Yes ☐ No **If no**, list address below.

Does Person 5 use tobacco? (required if age 18 or older) ☐ Yes ☐ No

Paying Your Plan Premium

Step 3: Select your payment option

Please select a premium payment option:

If you don't select a payment option, you will receive a bill each month.

☐ Receive a monthly bill

☐ Electronic funds transfer (EFT) from your bank account each month. Please complete the following authorization agreement for direct payments (ACH debits):

This is an authorization between MercyCare and_____, hereafter called Applicant, to initiate debits entries to: *(Select One)*

☐ Checking Account ☐ Savings Account

indicated at the depository financial institution named below, hereafter called Depository, and to debit the same to such account. Applicant acknowledges that the origination of ACH transactions to our account must comply with the provisions of U. S. law.

Additionally, Applicant hereby authorizes MercyCare to initiate credit entries to our account and the Depository to credit the same to such account, in the case where the incorrect amount has been debited to such account in error.

Depository Name:_____ Branch: _____

City:_____ State:_____ Zip:_____

Routing Number:_____ Account Number: _____

This authorization is to remain in full force and effect until MercyCare has received written notification from Applicant of Applicant's termination in such time and in such manner as to afford MercyCare and Depository a reasonable opportunity to act on it.

_____ _____

Print Name Signature

_____ _____

Date Effective Date *(if different than Date)*

Terms and Conditions

Step 4: Read the Terms and Conditions and Sign the Application

I acknowledge that I have read and completed the entire application. I agree that the answers are, to the best of my knowledge and ability, complete and true.

I understand that my answers are the basis for the policy that is issued. I agree that no insurance will be effective until the date specified by MercyCare on the policy.

I understand that any fraud or intentional misrepresentation of material fact relied upon by MercyCare may be used to deny a claim. I further understand that this contract can be voided if, within the first 24 months from the date of the policy, it is determined that I or a family member made an intentional misrepresentation of material fact in this application or performed an act, practice or omission that constitutes fraud.

I understand that I may request copies of this application and MercyCare's privacy practices. I agree that a photocopy is as valid as an original. A legible facsimile or electronic signature shall have the same force as the original. If my or my dependents' information has changed from what is indicated on the application prior to the effective date of coverage, I will immediately notify MercyCare about the change.

I understand that MercyCare may request additional information and documentation to confirm the information provided in this application, and that acceptance of this application may depend on my providing the requested information and documentation.

Signature of Applicant	Date of Signature (mm/dd/yyyy)
Signature of Spouse/Domestic Partner	Date of Signature (mm/dd/yyyy)
Signature(s) of Adult Children Age 18 or Older	Date of Signature (mm/dd/yyyy)