**OFFICE USE ONLY**

Agent/Broker Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Agent/Broker NPN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OEP\_\_\_\_\_\_\_\_\_\_\_\_SEP (type)\_\_\_\_\_\_\_\_\_\_\_Not Eligible\_\_\_\_\_\_\_\_

Agent/Broker Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



MercyCare Health Plans – MercyCare HMO, Inc.

P.O. Box 550 Janesville WI 53547

(608) 314-2508 (p) ⚫ (608) 314-2501 (f)

[mercycaresales@mhemail.org](mailto:mercycaresales@mhemail.org)

*Mercycarehealthplans.com*

***WISCONSIN* INDIVIDUAL DIRECT APPLICATION**

***Please Complete Entire Form in Ink***

Select one of the payment methods for **FIRST MONTH’S** premium:  Online Payment with Debit or Credit Card

Cash or Personal Check (Required with App)

**ACH for Future Payments - See Page 4**

Please Check Which MercyCare Plan You Want to Enroll In:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | | ***MercyCare HMO***  ***Gold Options*** | **Deductible**  **Individual / Family** | **Coinsurance** | **Out of Pocket Max**  **Individual / Family** | **Emergency Room/**  **Urgent Care** |
|  | | MercyCare Gold Standard  HIOS 58326WI0090021  Group # 4161 | $2,000 / $4,000 | 25% | $8,700 / $17,400 | ER: Deductible & Coinsurance  UC: $45 In-Network  UC: $45 Out of Network |
|  | | MercyCare Gold HDHP  HIOS 58326WI0090013  Group # 1383 | $3,000 / $6,000 | 0% | $3,000 / $6,000 | Deductible then 0% Coinsurance |
|  | | ***MercyCare HMO***  ***Silver Options*** | **Deductible**  **Individual / Family** | **Coinsurance** | **Out of Pocket Max**  **Individual / Family** | **Emergency Room/**  **Urgent Care** |
|  | | MercyCare Silver Option A  HIOS 58326WI0090002  Group # 1384 | $6,500 / $13,000 | 40% | $9,100 / $18,200 | ER: $300  UC: $100 In-Network  UC: $100 Out of Network |
|  | | MercyCare Silver Standard  HIOS 58326WI0090022  Group # 4162 | $5,800 / $11,600 | 40% | $8,900 / $17,800 | ER: Deductible & Coinsurance  UC: $60 In-Network  UC: $60 Out of Network |
|  | | Mercy Care Silver HDHP  HIOS 58326WI0090016  Group # 1386 | $5,400 / $10,800 | 0% | $5,400 / $10,800 | Deductible then 0% Coinsurance |
|  | ***MercyCare HMO***  ***Bronze Options*** | | **Deductible**  **Individual / Family** | **Coinsurance** | **Out of Pocket Max**  **Individual / Family** | **Emergency Room/**  **Urgent Care** |
|  | MercyCare Bronze Option A  HIOS 58326WI0090006  Group # 1387 | | $6,500 / $13,000 | 40% | $8,550 / $17,100 | Deductible then 40% Coinsurance |
|  | MercyCare Bronze Expanded  HIOS 58326WI0090023  Group # 4163 | | $7,500 / $15,000 | 50% | $9,000 / $18,000 | ER: Deductible & Coinsurance  UC: $75 In-Network  UC: $75 Out of Network |
|  | MercyCare Bronze HDHP  HIOS 58326WI0090024  Group # 4164 | | $9,100 / $18,200 | 0% | $9,100 / $18,200 | Deductible then 0% Coinsurance |

Requested Coverage Effective Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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**1 of 4**

**APPLICANT(S) INFORMATION**

**APPLICANT**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **First Name, Middle Initial, Last Name & Suffix:** | | | | | | | |
| **Permanent Residence Street Address (Must reside in Rock or Walworth County to be eligible:** | | | | | | | **Apartment/Suite #** |
| **City:** | **State:** | | | **Zip Code:** | | **County:** | |
| **Mailing Address if Different from Permanent Address:** | | | | | | | |
| **Phone Number:** | | **Primary Care Physician Name:** | | | **Email:** | | |
| **Date of Birth:**  **\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_** | **Gender:**  **🞏 Male**  **🞏 Female** | | **Social Security Number:**  **\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_** | | | **Tobacco User** (required if age 21 or older):  **🞏 Yes 🞏 No**  (Tobacco use is defined as use of tobacco products on average of 4 or more times per week in past 6 months) | |
| **Does anyone applying for coverage currently have health insurance 🞏 No 🞏 Yes** (If yes please fill in your insurance information below):  Current Insurance Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Provider Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Member ID #(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | |

**PERSON #2**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **First Name, Middle Initial, Last Name & Suffix:** | | | | **Relationship to Applicant:**  **🞏 Spouse/Domestic Partner**  **🞏 Dependent**  **🞏 Other** |
| **Does Person #2 live at the same address as Applicant 🞏 No 🞏 Yes** (If no please list address below): | | | | |
| **Is Person #2 Tobacco User** (required if age 21 or older): **🞏 Yes 🞏 No** | | **Primary Care Physician Name:** | | |
| **Date of Birth:**  **\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_** | **Gender:**  **🞏 Male 🞏 Female** | | **Social Security Number:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_** | |

**PERSON #3**

**2 of 4**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **First Name, Middle Initial, Last Name & Suffix:** | | | | **Relationship to Applicant:**  **🞏 Spouse/Domestic Partner**  **🞏 Dependent**  **🞏 Other** |
| **Does Person #3 live at the same address as Applicant 🞏 No 🞏 Yes** (If no please list address below): | | | | |
| **Is Person #3 Tobacco User** (required if age 21 or older): **🞏 Yes 🞏 No** | | **Primary Care Physician Name:** | | |
| **Date of Birth:**  **\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_** | **Gender:**  **🞏 Male 🞏 Female** | | **Social Security Number:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_** | |

**PERSON #4**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **First Name, Middle Initial, Last Name & Suffix:** | | | | **Relationship to Applicant:**  **🞏 Spouse/Domestic Partner**  **🞏 Dependent**  **🞏 Other** |
| **Does Person #4 live at the same address as Applicant 🞏 No 🞏 Yes** (If no please list address below): | | | | |
| **Is Person #4 Tobacco User** (required if age 21 or older): **🞏 Yes 🞏 No** | | **Primary Care Physician Name:** | | |
| **Date of Birth:**  **\_\_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_** | **Gender:**  **🞏 Male 🞏 Female** | | **Social Security Number:**  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_\_\_** | |

***For additional members, please put on separate piece of paper***

**TERMS AND CONDITIONS**

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 HMO, Inc. on the policy.

I understand that any fraud or intentional misrepresentation of material fact relied upon by MercyCare HMO, Inc. 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 HMO, Inc.’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 HMO, Inc. about the change.

I understand that MercyCare HMO, Inc. 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)

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**PAYING YOUR PLAN PREMIUM**

**First payment must be paid via cash, check, debit or credit card to effectuate coverage.**

***For every month thereafter***, how would you like to pay your monthly premium? 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):

------------------------------------------------------------------------------------------------------------------------------------------------------

**AUTHORIZATION AGREEMENT FOR DIRECT PAYMENT**

**ACH DEBIT AUTHORIZATION FORM**

This is an authorization between MercyCare Health Plans and \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Policy Holder’s Name or Account Holder); hereafter called Company/Member, to initiate debits/withdrawal from: **(Select One)**

🞏 Checking Account 🞏 Savings Account

Indicated at the depository financial institution named below: hereafter called DEPOSITORY, and to debit the same account for the monthly premium payment that is your responsibility. Furthermore, Company/Member hereby authorizes MercyCare Health Plans in the case of a clerical error to initiate credit entries to our account and the Depository to credit the same to such account. Company/Member acknowledges that the origination of ACH transactions to our account must comply with the provisions of U. S. Law.

Company/Member understands that if the funds are not available in my account, and ACH is returned to MercyCare Health Plans as NSF there can be an additional NSF Fee applied.

**ACH processing begins on the 10th of each month and may conclude in that following week**.

Depository Name (Bank name): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name on Bank Account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Checking Account Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bank Routing Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization is to remain in full force and effect until MercyCare Health Plans has received written notification from Company/Member of its termination by the first day of the month the ACH is scheduled to be processed in, afford MercyCare Health Plans and Depository a reasonable opportunity to act on notification.

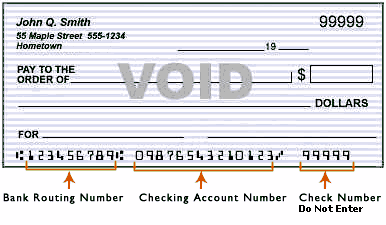
Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2nd Signature (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2nd Print Name (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_Zip Code: \_\_\_\_\_\_\_\_\_

**MercyCare Health Plans Name, Account Number of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please attach a voided check** 

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