MercyCare Health Plans™

Please return to Human Resources
Fax: 608-757-5512

Employee is choosing the following plan option:

_____

(Name of Plan)

P.O. Box 550
Janesville, WI 53547-0550
608-752-3431 Fax: 608-752-3751

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? ☐ No ☐ Yes
   If yes, fill out this section. Use extra paper if more than one additional policy will be in force.
2. Coverage Type: ☐ Medical Insurance ☐ Medicare
3. Insurance Company Name _____
4. Phone Number (with Area Code) _____
5. Policy Number _____
6. Policy Coverage dates_____ to _____
7. Name of Policyholder _____
8. Policyholder's Birthdate _____
9. Family Member's Covered _____
10. Policyholder's Employer Name _____
11. Employer Address _____
12. Employer Phone Number (with Area Code) _____
13. Name of Family Members Covered by Medicare _____
14. Medicare Claim Number _____
15. Medicare Part A Effective Date_____ Medicare Part B Effective Date _____
16. Is Medicare eligibility due to: ☐ Kidney Failure ☐ Disability
17. Are any of your dependents employed? ☐ Yes ☐ No

    If yes: Name of Employer:_____ Phone _____

    Address: _____

18. 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 _____