MercyCare Health Plans™

| 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.

I authorize any health care provider to release any of my medical information and any such information of any listed dependents, to the Company for the next 2 months when reasonable related to the coverage for which I have applied. If accepted for coverage, I also authorize any health care provider to release any of my medical information and any such information of any dependents accepted for coverage, to the Company and I authorize the Company to release such information to its vendors, suppliers, contractors, accrediting associations, providers and facilities and to my employer, when any such releases is reasonably related to coverage by the Company, including benefits, claims and eligibility issues, quality improvement and case management, but only while such coverage is in effect and for 30 months thereafter. I understand that we are entitled to inspect and receive a copy of the released information; that a copy of these authorizations is as valid as the original; and that I may revoke these authorizations by written notice at any time except to the extent that a health care provider has already acted in reliance on them. If any law or provider requires additional authorization for release of medical information, I will give this authorization.

**PRINT NAME** _____ **EMPLOYEE SIGNATURE** _____

**SPOUSE SIGNATURE** _____

**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 _____

If you are waiving, fill out waiver form and submit to HR by 11/14/19.
Form is available on the intranet or through Human Resources x5520