



MERCYCARE INSURANCE COMPANY

P.O. Box 2770
Janesville, WI 53547-2770
608-752-3431 Fax: 608-752-3751
ENROLLMENT APPLICATION

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

(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

Full Time Date of Hire (Month/Date/Year) Employer and Location

Application for Health Coverage (Check One)
Employee Only
Employee & Spouse
Employee +1
Employee/Child (ren)
Family
None/Declined

Current Marital Status (Check One)
Single
Married
Widowed
Divorced
Separated

OTHER HEALTH INSURANCE INFORMATION

1. On the day your coverage begins, 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 Dental Insurance Medicare

3. Insurance Company Name

4. Phone Number (with Area Code)

5. Policy Number

6. Policy Coverage 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

FAMILY INFORMATION

| Eligible Applicants Last Name/First Name | MI | Social Security # (REQUIRED) | Birth Date | Sex | Full Time College Student | Name of Physician | Currently a Patient? |
|---|----|--|---------------|-----|------------------------------|----------------------|-------------------------|
| Employee | | | | | | | Y/N |
| Spouse | | | | | | | Y/N |

List Children Oldest to Youngest

| | | | | | | | |
|-------|--|--|--|--|-----|--|-----|
| Child | | | | | Y/N | | Y/N |
| Child | | | | | Y/N | | Y/N |
| Child | | | | | Y/N | | Y/N |
| Child | | | | | Y/N | | Y/N |
| Child | | | | | Y/N | | 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** _____

FOR EMPLOYER USE ONLY

| | |
|--|---|
| Coverage Effective Date _____ | Reason for Enrollment (Check One) <input type="checkbox"/> Open Enrollment (if applicable) <input type="checkbox"/> New Hire <input type="checkbox"/> Qualifying Event _____ |
| Group Number _____ | |
| Authorized Signature (REQUIRED) _____ | |