

Group Enrollment Application (WI)

Please print or type

The background features a large, light blue graphic of the MercyCare logo, which consists of a stylized archway with three vertical columns. The text "MercyCare Health Plans" is overlaid on this graphic in a large, bold, blue serif font.

MercyCare Health Plans

MercyCare Insurance Company • MercyCare HMO, Inc.

PO Box 2770

Janesville, WI 53547-2770

608-752-3431 Fax: 608-752-3751

GROUP ENROLLMENT APPLICATION (WI)

EMPLOYEE INFORMATION

Employee Last Name _____

Employee First Name _____ Middle Initial _____

Social Security Number _____

Home Address _____ County _____

City _____ State _____ Zip Code _____

Employee's Home Telephone _____ Work _____

Employee's Birthday (Month/Date/Year) _____ Female Male

Date of Hire (Month/Date/Year) _____ Employer and Location _____

Application for Health Coverage (Check One)
--

- | | |
|---|--|
| <input type="checkbox"/> Employee Only | <input type="checkbox"/> Employee/Child (ren) |
| <input type="checkbox"/> Employee & Spouse | <input type="checkbox"/> Family |
| <input type="checkbox"/> Employee +1 | <input type="checkbox"/> None/Declined |

Current Marital Status (Check One)

- | | |
|---|---|
| <input type="checkbox"/> Single | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Married | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Widowed | |

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? Yes No

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 Birthday _____

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: _____

Address: _____

Phone Number: _____

18. Do any of your Eligible Dependents have Health Insurance through their Employment? 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 #	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

SIGNATURE (This form must be signed)

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 AND HEALTH PLAN USE ONLY

Coverage Effective Date _____
 Coverage Type _____
 Rx Number _____ Group Number _____
 Authorized Signature _____

Reason for Enrollment (Check One)
 Open Enrollment
 New Hire
 Qualifying Event

