Large Group Enrollment Application (IL)

Please print or type

PO Box 2770
Janesville, WI 53547-2770
608-752-3431 Fax: 608-752-3751

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)

- ☐ 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? ☐ 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 eligibilty 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		Y/N
Spouse					Y/N		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

**** Female members may also designate an OB/GYN or family practice specialist as a "women's principal health care provider" (WPHP) by noting "WPHP" next to the physician's name in this column. All services other than those of a women's principal health care provider should be arranged by, or provided by your Primary Care Physicians.**

SIGNATURE (This form must be signed)

I hereby enroll for benefits for which I am presently eligible or for which I may become eligible under my employer's group contract(s). I authorize deductions for this coverage from my earnings if any such deductions are required. I reserve the right to revoke this deduction authorization at any time upon written notice.

I consent to and authorize any physicians, medical practitioner, hospital, clinic, veterans administration facility, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. or Consumer Reporting Agency to disclose to MercyCare Insurance Company (or minor children's) records relating to my (or my children's) identity, diagnosis, prognosis or treatment. I understand that the specific type of information to be disclosed includes medical records, and that the purpose of this disclosure may be for an application for insurance, to obtain payment of an insurance claim, for a disability determination, for a vocational rehabilitation evaluation or for a legal investigation. I also understand that unless revoked in writing, this consent will remain in force for the period of time necessary to effectuate the purposes for which it is given.

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 ___________________________