

**Small Group Application (IL)**  
2-50 EMPLOYEES Please Print or Type



**MercyCare  
Insurance  
Company**

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

**EMPLOYEE INFORMATION**

Employee Last Name \_\_\_\_\_  
 Employee First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
 Home Address \_\_\_\_\_ County \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Home Telephone \_\_\_\_\_

**Application for Health Coverage (Check One)**

- Employee Only                       Employee/Child(ren)  
 Employee & Spouse               Family  
 Employee + 1                       None/Declined

**Current Marital Status (Check One)**

- Single                       Divorced  
 Married                       Separated  
 Widowed

**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
<b>List Children Oldest to Youngest</b>							
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 "woman'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 woman's principal health care provider should be arranged by, or provided by your Primary Care Physicians.**

**OTHER HEALTH INSURANCE INFORMATION/COORDINATION OF BENEFITS**

- On the day your coverage begins, will any family members, including those not listed above, 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.
- Coverage Type :  Medical Insurance  Dental Insurance  Medicare
- Insurance Company Name \_\_\_\_\_
- Phone Number (with Area Code) \_\_\_\_\_
- Policy Number \_\_\_\_\_
- Policy Coverage \_\_\_\_\_ to \_\_\_\_\_
- Name of Policyholder \_\_\_\_\_
- Policyholder's Birthday \_\_\_\_\_
- Family Member's Covered \_\_\_\_\_
- Policyholder's Employer Name \_\_\_\_\_

**OTHER HEALTH INSURANCE INFORMATION/COORDINATION OF BENEFITS (Continued)**

**Please Print First and Last 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?  No  Yes  
 If yes: Name of Employer: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone Number : \_\_\_\_\_
18. Do any of your Eligible Dependents have Health Insurance through their Employment?  No  Yes  
 If yes: Name of Dependent \_\_\_\_\_  
 Name of Insurance Company \_\_\_\_\_  
 Address of Insurance Company \_\_\_\_\_  
 Contract Number \_\_\_\_\_  
 Type of Coverage  Single  Family

**HEALTH QUESTIONNAIRE**

1. Within the last 24 months, have you or any of your dependents to be covered consulted, received treatment or had medication prescribed by a doctor, psychiatrist, psychologist, or other practitioner for any of the following: **Please circle below if applicable.** cancer, leukemia, hodgkins, lymphoma, stroke, diabetes, heart or vascular disease, mental or emotional disorder, muscular or systemic disease (such as arthritis or lupus), disorders of the liver, kidney, lung or intestine, or drug or alcohol disorders, asthma, bronchitis, pneumonia, chronic obstructive pulmonary disease (COPD), bone disease, deformity, polyps, colitis, crohns, cystic fibrosis, multiple sclerosis, headaches, heart murmur, irregular heartbeat, heart valve condition, hemorrhoid, rectal bleeding, high blood pressure, hypertension, abnormal pap smears, skin disorders, tumors or lumps, varicose veins/poor circulation.  
 No  Yes
2. Have you been diagnosed or treated by a member of the medical profession (other than AIDS tests) for AIDS, ARC or other immune system disorders?  No  Yes If Yes, what? \_\_\_\_\_
3. Have you or any of your dependents to be covered had medical claims that exceeded \$5,000 in the last 24 months for any illness, injury or hospitalization?  No  Yes  
 If Yes, why? \_\_\_\_\_
4. Are you or any of your dependents to be covered currently confined in a hospital or treatment facility, or has confinement in a hospital or treatment facility been scheduled or completed in the last 12 months?  No  Yes  
 If Yes, why? \_\_\_\_\_
5. In the past 12 months, have you or any of your dependents been disabled or been unable to work for one week or more?  No  Yes If Yes, why? \_\_\_\_\_

**IF ANY OF THE ABOVE QUESTIONS WERE ANSWERED "YES", INDICATE FULL DETAILS BELOW. ATTACH ADDITIONAL PAGES IF NECESSARY.**

NAME OF PERSON	DIAGNOSIS/CONDITION	DATES OF TREATMENT	DEGREE OF RECOVERY

6. Have you or any of your dependents to be covered received medication prescribed by a doctor, psychiatrist, psychologist, or other practitioner within the last 24 months?  No  Yes

**IF "YES", INDICATE FULL DETAILS BELOW. ATTACH ADDITIONAL PAGES IF NECESSARY.**

NAME OF PERSON	NAME OF DRUG	REASON FOR PRE-SCRIBED MEDICATION	DOSAGE OF MEDICATION	NAME/ADDRESS OF HOSPITAL & PHYSICIAN

7. Are you or any dependents now pregnant?  No  Yes If Yes, please indicate the due date \_\_\_\_\_  
 8. Have you of any of your dependents smoked or used tobacco in any form in the past year?  No  Yes

**SIGNATURE (This form must be signed)**

I hereby certify that I have read all preceding statements or that they have been read to me and that the above statements are true and completed to the best of my knowledge. And belief. I understand that any misrepresentation contained relied on by MercyCare Insurance Company may be used to reduce or deny a claim or void the contract within the contestable period if such misrepresentation materially affects the acceptance of the risk.

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. An Enrollment Form should not be submitted more than 60 DAYS prior to the effective date.

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 \_\_\_\_\_