

Individual Direct Enrollment Request Form

Office Use Only: _____
 Name of staff member/agent/broker (if assisted in enrollment): _____
 Staff member/agent/broker NPN: _____
 Effective Date of Coverage: _____
 OEP: _____ SEP (type): _____ Not Eligible: _____

Please contact MercyCare Health Plans if you need information in another language or format.

To enroll in MercyCare Individual Plans please provide the following information:

Please check which plan you want to enroll in:

- | | | | |
|--|-----------------------------------|-----------------------------------|---|
| <input type="checkbox"/> MercyCare Gold Plan | <input type="checkbox"/> Option A | <input type="checkbox"/> Option B | <input type="checkbox"/> Option C |
| <input type="checkbox"/> MercyCare Silver Plan | <input type="checkbox"/> Option A | <input type="checkbox"/> Option B | <input type="checkbox"/> Option C |
| <input type="checkbox"/> MercyCare Bronze Plan | <input type="checkbox"/> Option A | <input type="checkbox"/> Option B | <input type="checkbox"/> Option C <input type="checkbox"/> Option D |

Step 1: Tell us about yourself.

LAST Name:	FIRST Name:	Middle Initial	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms <input type="checkbox"/> Miss
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Birth Date: (____ / ____ / ____) (M M / D D / Y Y Y Y)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: ()	Alternate Phone Number: ()
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Permanent Residence Street Address: (Must reside in Rock, Walworth, or Green County to be eligible)

City:	County:	State:	ZIP Code:
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Mailing Address (only if different from your Permanent Residence Address):

Address:	City:	State:	ZIP Code:
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Email Address: _____

Social Security Number
 _____ - _____ - _____

Do You Use Tobacco? (required if age 18 or older) Yes No
 (Tobacco use is defined as use of tobacco on average of four or more times per week in past six months)

Does anyone applying for coverage currently have health insurance? Yes No

If Yes please fill in your insurance information below:
 Current Insurance Provider: _____
 Insurance Provider's Phone #: _____
 Member ID Number(s): _____

Tell us who else needs health coverage on next page.

Step 2: Tell us about anyone else who needs health coverage.

(If you have more people to include, make a copy of this page and attach.)

Person 2

LAST Name:	FIRST Name:	Middle Initial	Relationship to you: <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Dependent <input type="checkbox"/> Other _____
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Birth Date: (____ / ____ / ____) (M M / D D / Y Y Y Y)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number: _____ - ____ - _____
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Does Person 2 live at the same address as you? Yes No **If no**, list address below.Does Person 2 use tobacco? (required if age 18 or older) Yes No**Person 3**

LAST Name:	FIRST Name:	Middle Initial	Relationship to you: <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Dependent <input type="checkbox"/> Other _____
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Birth Date: (____ / ____ / ____) (M M / D D / Y Y Y Y)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number: _____ - ____ - _____
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Does Person 3 live at the same address as you? Yes No **If no**, list address below.Does Person 3 use tobacco? (required if age 18 or older) Yes No**Person 4**

LAST Name:	FIRST Name:	Middle Initial	Relationship to you: <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Dependent <input type="checkbox"/> Other _____
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Birth Date: (____ / ____ / ____) (M M / D D / Y Y Y Y)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number: _____ - ____ - _____
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Does Person 4 live at the same address as you? Yes No **If no**, list address below.Does Person 4 use tobacco? (required if age 18 or older) Yes No**Person 5**

LAST Name:	FIRST Name:	Middle Initial	Relationship to you: <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> Dependent <input type="checkbox"/> Other _____
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Birth Date: (____ / ____ / ____) (M M / D D / Y Y Y Y)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number: _____ - ____ - _____
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Does Person 5 live at the same address as you? Yes No **If no**, list address below.Does Person 5 use tobacco? (required if age 18 or older) Yes No

Paying Your Plan Premium

Step 3: Select your payment option

Please select a premium payment option:

If you don't select a payment option, you will receive a bill each month.

Receive a monthly bill

Electronic funds transfer (EFT) from your bank account each month. Please complete the following authorization agreement for direct payments (ACH debits):

This is an authorization between MercyCare and _____, hereafter called Applicant, to initiate debits entries to: *(Select One)*

Checking Account

Savings Account

indicated at the depository financial institution named below, hereafter called Depository, and to debit the same to such account. Applicant acknowledges that the origination of ACH transactions to our account must comply with the provisions of U. S. law.

Additionally, Applicant hereby authorizes MercyCare to initiate credit entries to our account and the Depository to credit the same to such account, in the case where the incorrect amount has been debited to such account in error.

Depository Name: _____ Branch: _____

City: _____ State: _____ Zip: _____

Routing Number: _____ Account Number: _____

This authorization is to remain in full force and effect until MercyCare has received written notification from Applicant of Applicant's termination in such time and in such manner as to afford MercyCare and Depository a reasonable opportunity to act on it.

Print Name

Signature

Date

Effective Date *(if different than Date)*

Terms and Conditions

Step 4: Read the Terms and Conditions and Sign the Application

I acknowledge that I have read and completed the entire application. I agree that the answers are, to the best of my knowledge and ability, complete and true.

I understand that my answers are the basis for the policy that is issued. I agree that no insurance will be effective until the date specified by MercyCare on the policy.

I understand that any intentional misrepresentation relied upon by MercyCare may be used to deny a claim. I further understand that this contract can be voided if within the first 24 months from the date of the policy it is determined that I or a family member made an intentional misrepresentation in the application.

I understand that I may request copies of this application and MercyCare's privacy practices. I agree that a photocopy is as valid as an original. A legible facsimile or electronic signature shall have the same force as the original. If my or my dependents' information has changed from what is indicated on the application prior to the effective date of coverage, I will immediately notify MercyCare about the change.

I understand that MercyCare may request additional information and documentation to confirm the information provided in this application, and that acceptance of this application may depend on my providing the requested information and documentation.

Signature of Applicant

Date of Signature(mm/dd/yyyy)

Signature of Spouse/Domestic Partner

Date of Signature(mm/dd/yyyy)

Signature(s) of Adult Children Age 18 or Older

Date of Signature(mm/dd/yyyy)