



# ENROLLMENT APPLICATION FORM

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**INCOMPLETE INFORMATION WILL DELAY PROCESSING YOUR APPLICATION AND PRODUCTION OF YOUR MEMBER ID CARD(S)**

- Base Plan
- Buy Up
- Conversion
- Coverage Waived

SUBSCRIBER INFORMATION				
SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> M <input type="checkbox"/> F	LAST NAME	FIRST NAME	M.I.
DATE OF BIRTH (M/D/Y) / /	STREET ADDRESS			
CITY	STATE	ZIP	COUNTY	
HOME PHONE ( ) ( )	BUSINESS PHONE ( ) ( )	FAX NUMBER ( ) ( )	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED	
PREFERRED METHOD OF COMMUNICATION <input type="checkbox"/> EMAIL <input type="checkbox"/> PHONE <input type="checkbox"/> MAIL <input type="checkbox"/> FAX		EMAIL ADDRESS		
EMPLOYER NAME		EMPLOYER ADDRESS		

CONTRACT TYPE	
COVERAGE:	<input type="checkbox"/> OPEN HMO <input type="checkbox"/> PPO IN AREA <input type="checkbox"/> REFERRED HMO <input type="checkbox"/> PPO OUT OF AREA <input type="checkbox"/> OPTION HMO <input type="checkbox"/> COBRA <input type="checkbox"/> OPEN POS <input type="checkbox"/> CONVERSION <input type="checkbox"/> OPTION POS <input type="checkbox"/> ASO <input type="checkbox"/> REFERRED POS <input type="checkbox"/> MYCHOICE <input type="checkbox"/> HDHP <input type="checkbox"/> HSA
CONTRACT TYPE:	<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> EMPLOYEE/CHILDREN <input type="checkbox"/> EMPLOYEE/SPOUSE <input type="checkbox"/> FAMILY

**RELEASE OF INFORMATION**

To obtain a Release of Information Form, contact Member Services (phone no. on back of ID card) or go to [www.mercyhealthplans.com](http://www.mercyhealthplans.com).

FAMILY INFORMATION										
ALL AREAS BELOW MUST BE FILLED OUT FOR EACH OF YOUR DEPENDENTS OR PROCESSING YOUR APPLICATION WILL BE DELAYED.										
If dependent has a last name different from that of the subscriber, or if dependent is disabled, please attach appropriate documentation from courts or physician.										
S.S. #	LAST NAME	FIRST NAME	M.I.	RELATIONSHIP	DATE OF BIRTH	SEX	ENROLLED IN MEDICARE?	OTHER COVERAGE?	PRIMARY CARE PHYSICIAN (PROVIDER)	PROVIDER I.D. NUMBER
				SELF	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
				SPOUSE	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
				CHILD	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
				CHILD	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
				CHILD	/ /	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		

EMPLOYER MUST COMPLETE
GROUP # _____
EMPLOYEE HIRE DATE _____
EFFECTIVE DATE OF COVERAGE _____
REASON FOR ENROLLMENT: <input type="checkbox"/> NEW EMPLOYEE <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> COBRA <input type="checkbox"/> TERMINATION DATE _____ <input type="checkbox"/> QUALIFYING EVENT EXPLAIN: _____
EMPLOYEE CLASSIFICATION: <input type="checkbox"/> HOURLY <input type="checkbox"/> SALARY <input type="checkbox"/> OTHER <input type="checkbox"/> ACTIVE <input type="checkbox"/> RETIRED
APPROVED BY: _____
DATE: _____

OTHER HEALTH INSURANCE INFORMATION	
OTHER GROUP COVERAGE INSURANCE	EFFECTIVE DATE _____ MEDICARE EFFECTIVE DATE _____
NAME OF OTHER INSURANCE CARRIER FOR EACH PERSON LISTED ABOVE	POLICY HOLDER _____
OTHER CARRIER'S CLAIMS ADDRESS	OTHER CARRIER'S PHONE NUMBER _____

MHP USE ONLY
ENTERED BY _____
DATE ENTERED _____

**IMPORTANT INFORMATION**

Please read the following information. It is part of the agreement between you and Mercy Health Plans of Missouri, Inc./Mercy Health Plans (collectively, "MHP").

- This may be considered my full and complete authorization to any physician, hospital or other necessary entity to allow full disclosure to MHP, of medical information relevant to persons covered by this application.
- This application is not in force until approved by MHP.
- Untruthful or misleading information provided on this application may render this application void and subject to cancellation within the first two (2) years.
- Any changes in eligibility must be reported to MHP immediately.
- If applying for an HSA, I agree to have Bank of America contact me to open an account.

Employee: \_\_\_\_\_

Date: \_\_\_\_\_

# AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

## NOTE:

It is required that this Authorization to Use and Disclose Protected Health Information be completed and submitted with the application. The application is not complete without this authorization form.

Each person age 18 or over who is to be covered by this policy is requested to sign at the bottom of this form. Failure to receive signatures for each person age 18 or over who is to be covered may affect premium issued by MHP, as permitted by law.

I authorize Mercy Health Plans (MHP) or its affiliates to obtain necessary individually identifiable health information, including but not limited to claims, medical records, reports, pharmaceutical records, diagnostic tests, and lab reports from physicians, hospitals or other health care providers pertaining to my care or the care of any other dependent(s) listed on the application for insurance. I understand that this information can be used to determine my/our eligibility for insurance, and that those records can be requested as far back as the past ten years.

I authorize MHP to share necessary information with my Producer (Broker or Agent). I understand that Mercy Health Plans may disclose individually identifiable health information, including but not limited to claims, medical records, reports, pharmaceutical records, diagnostic tests, and lab reports to other entities in the course of its business operations or as required or permitted by law or as set out in the Mercy Health Plans Notice of Privacy Practices and authorize such disclosure. I also understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

This authorization is valid for the duration of my coverage with Mercy Health Plans. I understand that this authorization is voluntary and that I may revoke this authorization at any time; however, if I do so before I am enrolled in the policy(ies), my application for coverage may be denied. A revocation request must be sent in writing to MHP's home address, or via e-mail. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

All listed applicants 18 years of age and older are requested to agree to the terms of this authorization. Signing this document confirms agreement. I understand and agree to the release of information for the purpose described above in this document.

**Signature:**

**Printed Name:**

**Relationship to Applicant:**

**Date:**

	<b>Signature:</b>	<b>Printed Name:</b>	<b>Relationship to Applicant:</b>	<b>Date:</b>
Applicant				
Applicant's Spouse				
Dependent Child 1				
Dependent Child 2				
Dependent Child 3				
Dependent Child 4				
Dependent Child 5				
Dependent Child 6				