Enrollment Application Form

14528 South Outer Forty, Suite 300
Chesterfield, Missouri 63017-5743
314.214.8196 or 800.327.0763
mercyhealthplans.com

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

SUBSCRIBER INFORMATION

SOCIAL SECURITY NUMBER	SEX M 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 ❒ SINGLE ❒ MARRIED ❒ DIVORCED ❒ WIDOWED

PREFERRED METHOD OF COMMUNICATION ❒ EMAIL ❒ PHONE ❒ MAIL ❒ FAX	EMAIL ADDRESS
EMPLOYER NAME	EMPLOYER ADDRESS

PRODUCTS

COVERAGE:	❒ OPEN HMO ❒ OPEN POS	❒ OPTION HMO ❒ OPTION POS	❒ REFERRED HMO ❒ REFERRED POS	❒ PPO ❒ COBRA	❒ CONVERSION
CONTRACT TYPE:	❒ EMPLOYEE	❒ EMPLOYEE/CHILDREN	❒ EMPLOYEE/SPOUSE	❒ FAMILY	

FAMILY INFORMATION

ALL AREAS BELOW MUST BE FILLED OUT FOR EACH OF YOUR DEPENDENTS OR PROCESSING YOUR APPLICATION WILL BE DELAYED.
If dependent is a full-time student over age 19, has a last name different from that of the subscriber, or if dependent is disabled, please attach appropriate documentation from school, courts or physician.

S.S. #	LAST NAME FIRST NAME M.I.	RELATION-SHIP	DATE OF BIRTH	SEX	ENROLLED IN MEDICARE?	OTHER COVERAGE?	PRIMARY CARE PHYSICIAN (PROVIDER)	PROVIDER I.D. NUMBER
		SELF	/ /		❒ YES ❒ NO	❒ YES ❒ NO		
		SPOUSE	/ /		❒ YES ❒ NO	❒ YES ❒ NO		
		CHILD	/ /		❒ YES ❒ NO	❒ YES ❒ NO		
		CHILD	/ /		❒ YES ❒ NO	❒ YES ❒ NO		
		CHILD	/ /		❒ YES ❒ NO	❒ YES ❒ NO		

RELEASE OF INFORMATION

Release of Information Designee:	**Release of Information Designee:**

OTHER HEALTH INSURANCE INFORMATION

OTHER GROUP COVERAGE INSURANCE EFFECTIVE DATE ____________ MEDICARE EFFECTIVE DATE ____________

NAME OF OTHER INSURANCE CARRIER FOR EACH PERSON LISTED ABOVE ____________

OTHER CARRIER'S CLAIMS ADDRESS	OTHER CARRIER'S PHONE NUMBER

IMPORTANT INFORMATION

Please read the following information. It is part of the agreement between you and Mercy Health Plans, Inc.

1. This may be considered my full and complete authorization to any physician, hospital or other necessary entity to allow full disclosure to Mercy Health Plans, of medical information relevant to persons covered by this application.
2. This application is not in force until approved by Mercy Health Plans.
3. Untruthful or misleading information provided on this application may render this application void and subject to cancellation. Non-payment of premiums or late payments may also result in cancellation.
4. Any changes in eligibility must be reported to Mercy Health Plans immediately.

Enrollee:	**Spouse:**	**Date:**

EMPLOYER MUST COMPLETE

GROUP #____________ EMPLOYEE HIRE DATE ____________ EFFECTIVE DATE OF COVERAGE ____________

REASON FOR ENROLLMENT ❒ NEW EMPLOYEE ❒ OPEN ENROLLMENT ❒ COBRA TERMINATION DATE ____________ ❒ QUALIFYING EVENT EXPLAIN: ____________

EMPLOYEE CLASSIFICATION ❒ HOURLY ❒ SALARY ❒ OTHER ____________ APPROVED BY: DATE

MHP USE ONLY

MHP MO 5113 (11/02)	ENTERED BY	DATE ENTERED