



ENROLLMENT APPLICATION FORM

14528 South Outer Forty • Suite 300 • Chesterfield, MO 63017 • 314.214.8196 or 800.327.0763 • mercyhealthplans.com

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
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
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 .

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").
1. 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.
2. This application is not in force until approved by MHP.
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 MHP immediately.
Employee: _____
Date: _____



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CONTRACT TYPE:	<input type="checkbox"/> EMPLOYEE	<input type="checkbox"/> EMPLOYEE/CHILDREN
	<input type="checkbox"/> EMPLOYEE/SPOUSE	<input type="checkbox"/> FAMILY

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				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		

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