



M-CARE Commercial and Medicaid HMO Health Plans

Member Enrollment Application

Unless this form is complete and correct, enrollment may be delayed.

Fax this application to:
M-CARE
Enrollment Department
Fax: (734) 332-2021

Mail this application to:
M-CARE
Enrollment Department
2301 Commonwealth Boulevard
Ann Arbor, MI 48105-2945

Contact Customer Service:
Phone: (734) 913-2211 or (800) 658-8878
Hearing Impaired: (800) 649-3777 (TDD)
Email: custserv@mcare.org
Website: www.mcare.org

Check one HMO PPO POS HMO Deductible HMO HSA PPO HSA

To be completed by the employer (check boxes where appropriate)

Group/company name	Assigned group/division number	Date of hire (required to process form) <input type="checkbox"/> Active <input type="checkbox"/> Retired	Effective date of coverage
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Enrollment <input type="checkbox"/> New enrollment <input type="checkbox"/> New hire <input type="checkbox"/> Rehire <input type="checkbox"/> Change to full-time <input type="checkbox"/> Re-enrollment <input type="checkbox"/> Return from leave/layoff <input type="checkbox"/> Loss of coverage <input type="checkbox"/> COBRA <input type="checkbox"/> Other (explain): _____	Change to existing contract Date of qualifying event: _____ <input type="checkbox"/> Open enrollment <input type="checkbox"/> Address change <input type="checkbox"/> Physician change <input type="checkbox"/> Marriage <input type="checkbox"/> Birth <input type="checkbox"/> Other (explain): _____
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To be completed by the employee (check boxes where appropriate)

Name			Social Security Number		Please use these codes to complete dependent relation code box CH Contract holder HD Handicapped dependent SP Spouse DC Dependent child SC Stepchild FC Unmarried child age 19-25	HMO AND POS ONLY (does not apply to PPO plan). Each member must select a primary care physician (PCP). PCPs include general or family practitioners, internists, or pediatricians. For more information, call Customer Service at (734) 913-2211 or (800) 658-8878. All medical and health care needs must be provided or arranged by your PCP. If a PCP is not selected, one will be assigned.
Last	First	Middle				
Address						
No./street			Apt./PO box/suite			
City		State	ZIP code	County		
Home phone	Work phone	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth			
		Married <input type="checkbox"/> Y <input type="checkbox"/> N				

List all covered individuals	Social Security Number	Sex M/F	Date of birth	Dependent relation code	Select a PCP (one for each member of the family). (Does not apply to PPO plan.)	Office number	Physician number	Is this person a current patient of this physician?
Self	"Same as above"			CH				Y N
								Y N
								Y N
								Y N
								Y N
								Y N

Please list additional dependents on additional form(s). **STAPLE** same-colored pages together after entering information.

Other health coverage (list any other health coverage for yourself or the listed dependents)

<input type="checkbox"/> Yes <input type="checkbox"/> No	Insurance company name* <small>*Please attach copy of plan/insurance company identification card</small>	Policy number	Effective date End date	Policy holder's name	Date of birth	Policy holder's employer
Are you covered by Medicare Parts A&B? <input type="checkbox"/> Yes* <input type="checkbox"/> No	Policy number Effective date <small>*Please attach copy of plan/insurance company identification card</small>	Is your spouse covered by Medicare parts A&B? <input type="checkbox"/> Yes* <input type="checkbox"/> No	Policy number Effective date <small>*Please attach copy of plan/insurance company identification card</small>	List everyone covered by other insurance		

I elect coverage and authorize any required deductions from my wages to pay for the coverage I have elected. I understand that the benefits for which I, and any dependents listed above, will be eligible are those described in the certificate of coverage. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance company, or other organization or institution that has any records or knowledge of the health of any member of my family to exchange such information with M-CARE/M-CARE PPO. Also, I hereby authorize the transmission of medical information for utilization, quality improvement, health management, health promotion, and wellness purposes. I attest that all information contained herein is true and complete to the best of my knowledge. If requested, I will furnish additional information to determine eligibility for myself and/or my dependents.

Employee signature: _____ **Date:** _____ **Authorized employer signature:** _____ **Phone number:** _____ **Date:** _____

White copy—Enrollment Department Yellow copy—Benefit Consultant Pink copy—Employer Gold copy—Employee

HMO • POS • PPO

M-CARE PPO is a product of the Michigan Health Insurance Company, a wholly owned subsidiary of M-CARE.

