

SERFF Tracking Number: MHPL-125641943 State: Arkansas
Filing Company: Mercy Health Plans State Tracking Number: 38997
Company Tracking Number: PHIAR-ENRL(05/08)
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: PHIAR_ENRL(05/08)
Project Name/Number: /

Filing at a Glance

Company: Mercy Health Plans
Product Name: PHIAR_ENRL(05/08) SERFF Tr Num: MHPL-125641943 State: ArkansasLH
TOI: H16G Group Health - Major Medical SERFF Status: Closed State Tr Num: 38997
Sub-TOI: H16G.001A Any Size Group - PPO Co Tr Num: PHIAR-ENRL(05/08) State Status: Approved-Closed
Filing Type: Form Co Status: Reviewer(s): Rosalind Minor
Author: Suzanne McGinnis Disposition Date: 05/16/2008
Date Submitted: 05/14/2008 Disposition Status: Approved-Closed
Implementation Date Requested: On Approval Implementation Date:
State Filing Description:

General Information

Project Name: Status of Filing in Domicile: Not Filed
Project Number: Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments:
Explanation for Combination/Other: Market Type: Group
Submission Type: New Submission Group Market Size: Small and Large
Overall Rate Impact: Group Market Type: Employer, Association
Filing Status Changed: 05/16/2008
State Status Changed: 05/16/2008 Deemer Date:
Corresponding Filing Tracking Number:
Filing Description:
See Attached Cover Letter

Company and Contact

Filing Contact Information

Suzanne McGinnis, Contract Specialist Suzanne.McGinnis@Mercy.net
Mercy Health Plans (314) 214-8263 [Phone]

SERFF Tracking Number: MHPL-125641943 State: Arkansas
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TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: PHIA-ENRL(05/08)
Project Name/Number: /

Chesterfield, MO 63017 (314) 214-8103[FAX]

Filing Company Information

Mercy Health Plans CoCode: 11529 State of Domicile: Missouri
14528 South Outer Forty Rd. Group Code: Company Type: LAH/PPO
Suite 300
Chesterfield, MO 63017 Group Name: State ID Number:
(314) 214-8100 ext. [Phone] FEIN Number: 48-1262342

SERFF Tracking Number: MHPL-125641943 State: Arkansas
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Project Name/Number: /

Filing Fees

Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation:
Per Company: No

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
94158	\$50.00	05/14/2008

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Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/16/2008	05/16/2008

SERFF Tracking Number: MHPL-125641943 State: Arkansas
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Project Name/Number: /

Disposition

Disposition Date: 05/16/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: MHPL-125641943 State: Arkansas
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 Product Name: PHIA-ENRL(05/08)
 Project Name/Number: /

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Form	Enrollment Application Form	Approved-Closed	Yes
Form	Status Change Form	Approved-Closed	Yes

SERFF Tracking Number: MHPL-125641943 State: Arkansas
 Filing Company: Mercy Health Plans State Tracking Number: 38997
 Company Tracking Number: PHIAR-ENRL(05/08)
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: PHIAR_ENRL(05/08)
 Project Name/Number: /

Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AR ENROLL v.4 (08)	Application/ Enrollment Form	Revised	Replaced Form #: AR ENROLL v.3 (08) Previous Filing #: MHPL-125487380		AR ENROLL v.4 (08).pdf AR ENROLL (01-08)-AR-CO-141-0507v3.pdf
Approved-Closed	AR GRP CHG v.2 (08)	Application/ Status Change Form Enrollment Form	Revised	Replaced Form #: AR GRP CHG (09) Previous Filing #: MHPL-125487380		AR GRP CHG v.2 (08).pdf AR GRP CHG FORM-2-08.pdf



ENROLLMENT APPLICATION FORM

521 President Clinton Avenue • Suite 700 • Little Rock, AR 72201 • 866-647-5568 • 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	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"/> PPO IN AREA <input type="checkbox"/> ASO <input type="checkbox"/> PPO OUT OF AREA <input type="checkbox"/> HDHP <input type="checkbox"/> COBRA <input type="checkbox"/> HSA <input type="checkbox"/> CONVERSION <input type="checkbox"/> MYCHOICE
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 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.	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. 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 within the first two (2) years. 4. Any changes in eligibility must be reported to Mercy Health Plans immediately. 5. If applying for an HSA, I agree to have Bank of America contact me to open an account.	Please note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. 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:

Applicant				
Applicant's Spouse				
Dependent Child 1				
Dependent Child 2				
Dependent Child 3				
Dependent Child 4				
Dependent Child 5				
Dependent Child 6				



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

RELEASE OF INFORMATION
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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.	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	
<p>Please read the following information. It is part of the agreement between you and Mercy Health Plans.</p> <ol style="list-style-type: none"> 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. This application is not in force until approved by Mercy Health Plans. 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 Mercy Health Plans immediately. If applying for an HSA, I agree to have Bank of America contact me to open an account. 	<p>Please note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.</p> <p>Employee: _____ Date: _____</p>

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 must sign at the bottom of this form.

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 must 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:

Applicant				
Applicant's Spouse				
Dependent Child 1				
Dependent Child 2				
Dependent Child 3				
Dependent Child 4				
Dependent Child 5				
Dependent Child 6				



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 Little Rock, AR 72201
 866-647-5568
 mercyhealthplans.com

CHECK APPLICABLE BOX:

- TERMINATION**
 Entire Family
 Dependent(s)
- CHANGE**
 Demographics
 Add new dependent

Status Change Form

(Please Print)

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

SUBSCRIBER INFORMATION

CHANGE REQUESTED: NAME ADDRESS PHONE NUMBER PRIMARY CARE PHYSICIAN GROUP NUMBER

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 _____

FAMILY INFORMATION

ALL AREAS BELOW MUST BE FILLED OUT FOR EACH OF YOUR DEPENDENTS OR PROCESSING YOUR CHANGES WILL BE DELAYED.

If dependent is a full-time student over age 19, has a last name different from that of the participant, or if dependent is disabled, please attach appropriate documentation from school, courts or physician.

Add or Delete*	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	/ /		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
					SPOUSE	/ /		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
					CHILD	/ /		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
					CHILD	/ /		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
					CHILD	/ /		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		

*REASON FOR CHANGE: LAYOFF RESIGNATION TERMINATION DEATH COBRA MARRIAGE DIVORCE ADOPTION BIRTH QMCSO

RELEASE OF INFORMATION

Please refer to the attached "Authorization to Use & Disclose Protected Health Information."

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 _____

IMPORTANT INFORMATION

I attest that the information provided on this form is accurate and complete. I understand and agree that any omissions or incorrect statements made intentionally on this form may render our coverage invalid. Please note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Enrollee: _____ Spouse: _____ Date: _____

EMPLOYER MUST COMPLETE

GROUP # _____ EFFECTIVE DATE OF CHANGE _____

REASON FOR CHANGE: OPEN ENROLLMENT QUALIFYING EVENT (EXPLAIN) _____

APPROVED BY: _____ DATE _____ Active Retired

MHP USE ONLY

AR GRP CHG v.2 (08) ENTERED BY: _____ DATE ENTERED _____

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 Status Change Form.**

The Status Change Form is not complete without this authorization form.

**Each person age 18 or over who is to be added to your coverage 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 persons 18 years of age and older who are listed on the Status Change Form 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:

Applicant				
Applicant's Spouse				
Dependent Child 1				
Dependent Child 2				
Dependent Child 3				
Dependent Child 4				
Dependent Child 5				
Dependent Child 6				



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 Little Rock, AR 72201
 866-647-5568
 mercyhealthplans.com

CHECK APPLICABLE BOX:

- TERMINATION CHANGE
 Entire Family Demographics
 Dependent(s) Add new dependent

Status Change Form

(Please Print)

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

SUBSCRIBER INFORMATION

CHANGE REQUESTED: NAME ADDRESS PHONE NUMBER PRIMARY CARE PHYSICIAN GROUP NUMBER

SOCIAL SECURITY NUMBER SEX LAST NAME FIRST NAME M.I.
 M F

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 ADDRESS
 EMAIL PHONE MAIL FAX

EMPLOYER NAME EMPLOYER ADDRESS

FAMILY INFORMATION

ALL AREAS BELOW MUST BE FILLED OUT FOR EACH OF YOUR DEPENDENTS OR PROCESSING YOUR CHANGES WILL BE DELAYED.

If dependent is a full-time student over age 19, has a last name different from that of the participant, or if dependent is disabled, please attach appropriate documentation from school, courts or physician.

Add or Delete*	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"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
					SPOUSE	/ /		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
					CHILD	/ /		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
					CHILD	/ /		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
					CHILD	/ /		<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		

*REASON FOR CHANGE LAYOFF TERMINATION COBRA DIVORCE BIRTH
 RESIGNATION DEATH MARRIAGE ADOPTION QMCSO

RELEASE OF INFORMATION

Each person age 18 or over who is being added to the coverage must sign the attached "Authorization to Use & Disclose Protected Health Information."

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

IMPORTANT INFORMATION

I attest that the information provided on this form is accurate and complete. I understand and agree that any omissions or incorrect statements made intentionally on this form may render our coverage invalid. Please note: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Enrollee: _____ Spouse: _____ Date: _____

EMPLOYER MUST COMPLETE

GROUP # _____ EFFECTIVE DATE OF CHANGE _____

REASON FOR CHANGE OPEN ENROLLMENT QUALIFYING EVENT (EXPLAIN) _____

APPROVED BY: _____ DATE _____ Active Retired

MHP USE ONLY

AR-CO-111-0506 ENTERED BY: _____ DATE ENTERED _____
 AR GRP CHG (09)

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 Status Change Form.**

The Status Change Form is not complete without this authorization form.

Each person age 18 or over who is to be added to your coverage must sign at the bottom of this form.

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 persons 18 years of age and older who are listed on the Status Change Form must 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:

Applicant				
Applicant's Spouse				
Dependent Child 1				
Dependent Child 2				
Dependent Child 3				
Dependent Child 4				
Dependent Child 5				
Dependent Child 6				

SERFF Tracking Number: MHPL-125641943 State: Arkansas
Filing Company: Mercy Health Plans State Tracking Number: 38997
Company Tracking Number: PHIAR-ENRL(05/08)
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: PHIAR_ENRL(05/08)
Project Name/Number: /

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: MHPL-125641943 State: Arkansas
Filing Company: Mercy Health Plans State Tracking Number: 38997
Company Tracking Number: PHIAR-ENRL(05/08)
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: PHIAR_ENRL(05/08)
Project Name/Number: /

Supporting Document Schedules

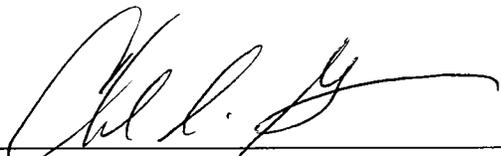
Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 05/16/2008
Comments:
Attachment:
AR PPO Certification_Notice .pdf

Bypassed -Name: Application **Review Status:** Approved-Closed 05/16/2008
Bypass Reason: Form number and date of application being replaced is in Cover Letter.
Comments:

Satisfied -Name: Cover Letter **Review Status:** Approved-Closed 05/16/2008
Comments:
See Cover Letter attached.
Attachment:
AR Enroll_Status Forms - SERFF Filing Cover Ltr_05.14.08.pdf

CERTIFICATION

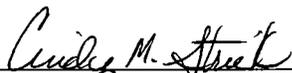
I, Charles S. Gilham, am a duly authorized officer of Mercy Health Plans and do hereby certify that, per Rule and Regulation 19 and 42, Section 5 (b), there will be no unfair discrimination with respect to the medical/lifestyle application questions and underwriting standards.


Charles S. Gilham, Vice President General Counsel
Mercy Health Plans
14528 S. Outer 40, Suite 300
Chesterfield, MO 63017
cgilham@mhp.mercy.net
(314) 214-8294

5-9-08
Date

STATE OF Missouri
COUNTY OF St. Louis

Subscribed and sworn to before me this 9th day of May, 2008.


Signature of Notary Public

Cindy M. Strick
Printed Name of Notary Public

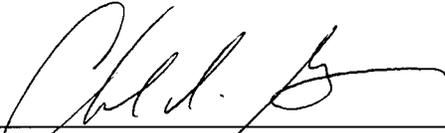
In and for the State of Missouri
My Commission expires: 11-19-2010

(NOTARY SEAL)

CINDY M. STRICK
My Commission Expires
November 19, 2010
St. Louis County
Commission #00488114

CERTIFICATION

I, Charles S. Gilham, a duly authorized officer of Mercy Health Plans with the title of Secretary, do hereby certify that all benefits payable will comply with the Arkansas Bulletin 9-85 and that the difference between network and non-network deductibles, copays and coinsurances will not exceed 25%.



Charles S. Gilham, Vice President General Counsel
Mercy Health Plans
14528 S. Outer 40, Suite 300
Chesterfield, MO 63017
cgilham@mhp.mercy.net
(314) 214-8294

5-9-08

Date



May 14, 2008

Ms. Rosalind Minor
Senior Certified Rate and Form Analyst
Arkansas Insurance Department
Life and Health Division
1200 West Third Street
Little Rock, AR 72201-1904

RE:

AR ENROLL v.4 (08)	Enrollment Application Form
AR GRP CHG v.2 (08)	Status Change Form

Dear Ms. Minor:

I have enclosed the above referenced documents submitted for your review and approval. These forms are revisions of those listed below and will be used by Mercy Health Plans as enrollment applications for our PPO product. I have also attached the following:

- The required Policy Form Compliance Certification
- Filing fee of \$50 will be forwarded by mail

The documents submitted are revisions of the following:

Form Number	Description	Date Approved
AR ENROLL v.3 (08)	Enrollment Application Form	2/21/08
AR GRP CHG (09)	Status Change Form	2/21/08

As you can see these forms were recently reviewed and approved; however, we have –

- Changed the address to reflect new office location on both forms
- Revised the HIPAA compliant language requiring signatures on page two of these forms.

If you have any questions, please contact me by phone at (314) 214-8263 or by email at smcginni@mhp.mercy.net.

Sincerely,

A handwritten signature in cursive script that reads "Sue McGinnis".

Sue McGinnis
Contract Specialist

Attachment