

SERFF Tracking Number: MHPL-126290492 State: Arkansas
 Filing Company: Mercy Health Plans State Tracking Number: 43391
 Company Tracking Number: PHARAPPSUPP_09
 TOI: H16I Individual Health - Major Medical Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
 Product Name: PHARAPPSUPP/09
 Project Name/Number: PHARAPPSUPP/09/

Filing at a Glance

Company: Mercy Health Plans
 Product Name: PHARAPPSUPP/09 SERFF Tr Num: MHPL-126290492 State: Arkansas
 TOI: H16I Individual Health - Major Medical SERFF Status: Closed-Approved- State Tr Num: 43391
 Closed
 Sub-TOI: H16I.005A Individual - Preferred Provider (PPO) Co Tr Num: PHARAPPSUPP_09 State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor
 Authors: Karen Hosack, Suzanne McGinnis Disposition Date: 09/02/2009
 Date Submitted: 09/02/2009 Disposition Status: Approved-Closed
 Implementation Date Requested: On Approval Implementation Date:
 State Filing Description:

General Information

Project Name: PHARAPPSUPP/09 Status of Filing in Domicile:
 Project Number: Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Group Market Size:
 Overall Rate Impact: Group Market Type:
 Filing Status Changed: 09/02/2009 Explanation for Other Group Market Type:
 State Status Changed: 09/02/2009
 Deemer Date: Created By: Suzanne McGinnis
 Submitted By: Suzanne McGinnis Corresponding Filing Tracking Number:
 Filing Description:
 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

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RE: PHI AR APP/SUPP (9-09)
NAIC: 11529

Dear Ms. Minor:

I have attached a supplemental application question regarding replacement in compliance with AR Rule and Regulation 18 s. 9. This supplemental question is a new form that will be attached to the Application form number PHI AR INDIV APP/ LT (01/08) that was approved on 1/23/2008. I have attached a copy of this application under "Supporting Documentation" for convenience.

Please contact me at (314) 214-2342 or by email at khosack@mhp.mercy.net if you have any questions.

Sincerely,
Karen Hosack, MHP, CCP
Compliance Analyst

Company and Contact

Filing Contact Information

Karen Hosack, Compliance Analyst
Mercy Health Plans
14528 South Outer Forty Rd.
Suite 300
Chesterfield, MO 63017

khosack@mhp.mercy.net
314-214-2342 [Phone]
314-214-8103 [FAX]

Filing Company Information

Mercy Health Plans
14528 South Outer Forty Rd.
Suite 300
Chesterfield, MO 63017
(314) 214-8100 ext. [Phone]

CoCode: 11529
Group Code:
Group Name:
FEIN Number: 48-1262342

State of Domicile: Missouri
Company Type: LAH/PPO
State ID Number:

Filing Fees

SERFF Tracking Number: MHPL-126290492 State: Arkansas
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Fee Required? Yes
Fee Amount: \$50.00
Retaliatory? No
Fee Explanation:
Per Company: No

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
0000202576	\$50.00	08/14/2009
	\$0.00	

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/02/2009	09/02/2009

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Disposition

Disposition Date: 09/02/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Supplemental Question to the Individual Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	PHI AR APP/SUPP 09/02/2009 (9-09)	Application/Supplemental Enrollment Form	Question to the Individual Application	Initial			Replacement Question_09.1.09.pdf



Mercy Health Plans
 521 President Clinton Avenue • Suite 700
 Little Rock, AR 72201
 [(501) 372-0065] [800-330-8293]
 www.mercyhealthplans.com

Supplemental Question to the Individual Application



EXISTING COVERAGE AND REPLACEMENT

1. Are any applicants covered by other health insurance now?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If 'Yes', Complete section below:		
2. Will the Mercy Health Plans' coverage that you are applying for replace or change your current hospital, medical or major medical insurance?*	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Will any applicants be continuing any other health insurance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3.(a) If 'Yes', list name(s) : _____ _____		

I understand that this supplemental question is attached to and becomes part of my Mercy Health Plans application and that I have read the attached "Notice to Applicant".

 Applicant's Signature

_____/_____/_____
 Date

* NOTE: If health insurance is being replaced, please read the attached "Notice to Applicant".

**NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND HEALTH INSURANCE**

According to your application, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by Mercy Health Plans. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have and pre-existing conditions may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Please see attached Certification Rule & Regulation 19 Attachment: AR Certification_INDIV App Supp_09.pdf	Approved-Closed	09/02/2009

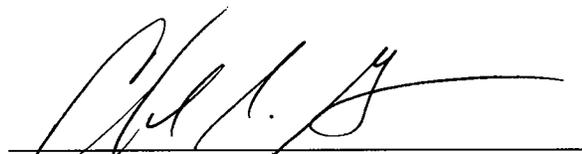
	Item Status:	Status Date:
Satisfied - Item: Application Comments: AR INDIV Application_ PHI AR INDIV APP/LT (01/08) Approved 1/23/08 Attachment: AR INDIV Application.pdf	Approved-Closed	09/02/2009

	Item Status:	Status Date:
Bypassed - Item: Health - Actuarial Justification Bypass Reason: N/A Comments:	Approved-Closed	09/02/2009

	Item Status:	Status Date:
Bypassed - Item: Outline of Coverage Bypass Reason: N/A Comments:	Approved-Closed	09/02/2009

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.



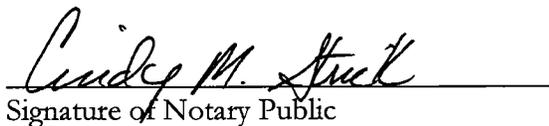
Charles S. Gilham, Vice President General Counsel
Mercy Health Plans
14528 S. Outer 40, Suite 300
Chesterfield, MO 63017
cgilham@mhp.mercy.net
(314) 214-8294

8-13-09

Date

STATE OF Missouri
COUNTY OF St. Louis

Subscribed and sworn to before me this 13th day of August, 2009.



Signature of Notary Public

Cindy M. Strick
Printed Name of Notary Public

In and for the State of Missouri
My Commission expires: 11-19-10

(NOTARY SEAL)



CINDY M. STRICK
My Commission Expires
November 19, 2010
St. Louis County
Commission #06483114



Mercy Health Plans
 500 President Clinton Avenue • Suite 20
 Little Rock, AR 72201
 [(501) 372-0065] [866-450-3249]
 www.mercyhealthplans.com

Application for Individual Comprehensive Health Insurance Coverage

[Applying electronically will allow you to receive a faster response. Apply online at www.mercyhealthplans.com. For questions about the MercyOne electronic application please contact a Mercy Health Plans representative at [1.877.MyMercy (1.877.696.3729)] [1.800.404.9878].]

Applicant Information

Please enter the following applicant information. (If applying for Child Only Coverage, the child's information goes here. Please submit a separate application for each Child Only Applicant.)

NAME:	First	Middle	Last
ADDRESS:	Street	City	State Zip County
Home Phone #: (including area code)	Work Phone #: (including area code)	E-mail Address	

General Member Information: Please fill out information below for any family members who are applying for coverage (attach other pages, if needed).

First	Name		Relationship to Applicant	Sex M/F	Height		Weight Lbs.	SSN#	Date of Birth (mm/dd/yyyy)		
	MI	Last			Ft.	In.					
			Self								
			Spouse								
			Child								
			Child								
			Child								
			Child								
			Child								
			Child								

Producer Information:

If you have a Producer (Broker or Agent) that will be assigned to your account, HAVE HIM/HER COMPLETE THIS SECTION.

Note: Mercy Health Plans (MHP) may share medical information with the Producer concerning you or your covered dependents that is contained in this application or discovered in the course of processing the application. The writing (and any assisting) Producer's current Arkansas health insurance license must be on file with MHP prior to acceptance of this application.

Do you know of any significant medical information relating to the applicant or any of his dependents that has not been reported on this form? Yes No

For purposes of processing commission, please provide the following information*:

Agency Name: _____ Broker's Name: _____

Broker's Telephone # _____ Broker's Email: _____

Broker's Signature: _____ Date: _____

Notification: Broker Only

Broker and Subscriber

*Please fill out this information as it appears on your W-9 form.

Coverage and Benefit Selection:

To choose the type of coverage that you would like, select ONE option from EACH of the sections numbered 1, 2, and 3, 4) below.

- 1) Type of coverage: Applicant only (Ages 19-65 yrs.) Child Only (Age 6 mo -18 yrs) Applicant & spouse
 Applicant & unmarried children* Applicant, spouse & unmarried children*
 *Unmarried children under age 19, or who are full time students (FTS) through the date on which they turn 23 may be added to the plan. FTS documentation must accompany application. Call us for details on FTS documentation at [(501) 372-0065] [866-450-3249].

2) Effective date requested: ___/___/___ Note: The actual effective date will be determined by Mercy Health Plans.

- 3) OPTIONAL BENEFITS: Coverage for Temporomandibular Joint Disorder (TMJ) – Additional \$ ___/month Yes No
 Family Services Coverage – Additional \$ ___/month Yes No

4) Select Plan Option: Choose ONLY ONE Plan option.
 Note: Maternity benefits apply only to the applicant or applicant’s spouse, and will not begin for one year.

Plan	Term Length	Maternity	In- Network Deductible	Out of- Network Deductible	Office Visit	Coinsurance	Prescription Copays
<input type="checkbox"/> ARK-A	12 month	No	\$1,000	\$2,000	\$15/\$35	100/75%	\$10/\$40/\$65
<input type="checkbox"/> ARK-B	12 month	No	\$2,500	\$5,000	\$15/\$35	100/75%	\$10/\$40/\$65
<input type="checkbox"/> ARK-C	12 month	No	\$5,000	\$10,000	\$15/\$35	100/75%	\$10/\$40/\$65
<input type="checkbox"/> ARK-AA	12 month	Yes	\$1,000	\$2,000	\$15/\$35	100/75%	\$10/\$40/\$65
<input type="checkbox"/> ARK-BB	12 month	Yes	\$2,500	\$5,000	\$15/\$35	100/75%	\$10/\$40/\$65
<input type="checkbox"/> ARK-CC	12 month	Yes	\$5,000	\$10,000	\$15/\$35	100/75%	\$10/\$40/\$65
<input type="checkbox"/> ARK-D	12 month	No	\$500	\$1,000	\$15/\$35	80/60%	\$10/\$40/\$65
<input type="checkbox"/> ARK-E	12 month	No	\$1,000	\$2,000	\$15/\$35	80/60%	\$10/\$40/\$65
<input type="checkbox"/> ARK-F	12 month	No	\$2,500	\$5,000	\$15/\$35	80/60%	\$10/\$40/\$65
<input type="checkbox"/> ARK-G	12 month	No	\$5,000	\$10,000	\$15/\$35	80/60%	\$10/\$40/\$65
<input type="checkbox"/> ARK-DD	12 month	Yes	\$500	\$1,000	\$15/\$35	80/60%	\$10/\$40/\$65
<input type="checkbox"/> ARK-EE	12 month	Yes	\$1,000	\$2,000	\$15/\$35	80/60%	\$10/\$40/\$65
<input type="checkbox"/> ARK-FF	12 month	Yes	\$2,500	\$5,000	\$15/\$35	80/60%	\$10/\$40/\$65
<input type="checkbox"/> ARK-GG	12 month	Yes	\$5,000	\$10,000	\$15/\$35	80/60%	\$10/\$40/\$65

Health History:

Complete your health history by answering “Yes” or “No” to the questions in the following section.

- 1) Have you or any family member(s) who are applying for coverage smoked or used other smokeless tobacco products within the last 12 months? Yes No
- 2) Are you, or any family member(s) who are applying for coverage currently pregnant? Yes No
- 3) Do you or any family member(s) who are applying for coverage have any health conditions that a reasonably prudent person would anticipate requiring future medical treatment or surgery within the next 12 months? Yes No

If so, what are those health conditions, and what treatments are considered? (Attach other pages if needed)

- 4) In the last ten years have you or any family member(s) applying for coverage had any signs, symptoms, indications, diagnoses or treatments of any disease, disorder or injury, or had any test results that were abnormal?

If so, what are those disease states, injuries or abnormal test results? (Attach other pages if needed)

Yes No

- 5) Are you or any family member(s) applying for coverage taking any drugs prescribed by a physician or any over the counter drugs? Yes No

List below: 1) all prescription or over-the-counter drugs that are taken, 2) the person for whom each drug is prescribed, 3) the prescribing physician and 4) the conditions that the drugs are prescribed to treat (attach other pages, if needed).

It is important to note that if you are taking any prescribed medication, you should answer "Yes" to one or more of the questions relating to organ systems/diseases in number six (6) below.

Name of Drug:	Person Drug Prescribed For:	Condition Drug Prescribed to Treat:	Prescribing Physician

- 6) Have you or any family member(s) applying for coverage current have or been diagnosed or treated for any health conditions or diseases (either Inpatient, Outpatient or Emergency Room) pertaining to the following organ systems or diseases?

Check "Yes" or "No" for all conditions listed below as they apply for any covered family member. NOTE: If you answer "Yes" to any of these screening questions you must also answer the Secondary Questions related to those conditions attached to this form. Refer to page number listed in the Secondary Questions to the Application for Individual Health insurance.

Yes*	No		Yes*	No	
<input type="checkbox"/> *	<input type="checkbox"/>	1. Diabetes/Sugar in Urine/Abnormal Blood Sugar/Pre-Diabetes, [pg *]	<input type="checkbox"/> *	<input type="checkbox"/>	11. Epilepsy/Seizure Disorder, [pg*]
<input type="checkbox"/> *	<input type="checkbox"/>	2. Endocrine/Thyroid/Pituitary/Adrenal, [pg *]	<input type="checkbox"/> *	<input type="checkbox"/>	12. Mental or Psychiatric Condition/Depression/Behavioral or Eating Disorder, [pg *]
<input type="checkbox"/> *	<input type="checkbox"/>	3. High Blood Pressure/Hypertension, [pg *]	<input type="checkbox"/> *	<input type="checkbox"/>	13. Drug or Alcohol Abuse, [pg *]
<input type="checkbox"/> *	<input type="checkbox"/>	4. Heart/Circulatory/Stroke/Aneurysm/Cholesterol, [pgs *]	<input type="checkbox"/> *	<input type="checkbox"/>	14. Back or Neck Disorder, [pg *]
<input type="checkbox"/> *	<input type="checkbox"/>	5. Respiratory/Lung/Asthma/TB/COPD, [pg *]	<input type="checkbox"/> *	<input type="checkbox"/>	15. Arthritis/Bone/Joint Disorder, [pgs *]
<input type="checkbox"/> *	<input type="checkbox"/>	6. Ears/Eyes/Nose/Throat/Skin Disorder, [pg *]	<input type="checkbox"/> *	<input type="checkbox"/>	16. Muscular Disorder/Lupus, [pg *]
<input type="checkbox"/> *	<input type="checkbox"/>	7. Digestive/Intestinal/Liver Disorder/Acid Reflux/Crohn's, [pgs *]	<input type="checkbox"/> *	<input type="checkbox"/>	17. Cancers/Tumors/Cysts/Polyps, [pgs *]
<input type="checkbox"/> *	<input type="checkbox"/>	8. Prostate/Reproductive Organ Disorder/Infertility/STD, [pg *]	<input type="checkbox"/> *	<input type="checkbox"/>	18. HIV/AIDS/ARC/Auto-Immune Disorder, [pg *]
<input type="checkbox"/> *	<input type="checkbox"/>	9. Urinary Tract/Kidney or Renal Disease, [pg *]	<input type="checkbox"/> *	<input type="checkbox"/>	19. Any Other Illness, Disease or Injury, [pg *]
<input type="checkbox"/> *	<input type="checkbox"/>	10. Nervous System/Brain Disorder/Headache, [pg*]			

*** Please answer the Secondary Questions pertaining to these conditions for every "Yes" response.**

- 7) Primary physician name and phone number: _____

Date of last physical exam: ____ / ____ / ____.

Statements of Understanding:

Please read all statements below. Each person, age 18 or over, to be covered on this policy will need to sign at the bottom of this form.

1. I understand that this is an application only, and I should not cancel any coverage that I currently have until I am notified of acceptance for coverage by Mercy Health Plans.
2. I understand that I will receive either an acceptance or denial from MHP or a letter explaining the reason for the delay, within 60 days of MHP's receipt of this application
3. I understand that if the bank returns any payments due to insufficient funds, I will be assessed a fee. Additionally, I understand that if my premiums are not paid within the billing grace period, my coverage will be terminated as to the date when my premiums were paid in full.
4. I understand that if a Producer (Agent or Broker) is handling my request, the agent is not authorized to waive a complete answer to any question, make a decision as to insurability, make or alter any contract or waive any other rights or requirements of Mercy Health Plans.
5. I understand that if I or any covered family members am/are accepted for medical coverage, any pre-existing medical condition disclosed within this application will not be covered for up to 12 months after my effective date.
6. I understand that if any pre-existing condition(s) is/are subsequently discovered that were not disclosed during the application process, benefits will be withheld for 12 months for that condition or the coverage will be rescinded in its entirety at MHP's discretion.
7. I understand that I or any of my covered family members may need to obtain a physical examination at my own expense prior to acceptance for coverage, if such an examination has not been performed within the last two years.
8. I understand that I or any of my covered family members must notify Mercy Health Plans if we seek and receive medical attention between the time this application is completed and the effective date of coverage. In this situation, MHP has the right to re-underwrite the application using this new information, and the decision to provide coverage may change.
9. I understand that if I purchase maternity benefits, they apply only to my spouse or me and do not begin until we have been covered for 12 months under the plan that includes the maternity benefit. Maternity benefits are not available for our dependent children and do not apply to child only plans.
10. I understand and agree that Mercy Health Plans may obtain information needed to process this application from me, my physician(s) and medical or pharmaceutical databases. A Mercy Health Plans' employee will then review this information. Any and all additions or corrections will then become part of the application. I understand that Mercy Health Plans will rely on this form and any information received to issue coverage.
11. I understand that if I omit or falsify information in a manner that is considered fraudulent or intentionally misleading, this may result in the cancellation of this coverage based on the terms of the policy. I agree to promptly repay any benefit payment(s) to which my covered family member(s) and/or I were not entitled.
12. I understand and agree that other health insurance coverage that I have might reduce my benefits under this Policy.

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.

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, diagnostics 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, diagnostics 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 redisclosure 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 to MHP in writing to our 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.

By signing, I agree that I have fully read this entire application, and I understand and agree with all statements contained herein:

	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				

**Note: Coverage will not begin until all necessary information is received by MHP.
MHP will notify you of the approved effective date.**

Payment Information:

All premium payments are made **either** via debit ACH (automatic withdrawal) from your bank or by credit card*.

Please check your method of payment:

Automatic Bank Account Withdrawal

Checking account (attach voided check below)

Savings Account

Account # _____

Routing # _____

Credit Card

VISA

MasterCard

Cardholder's Name (as it appears on the card):

Billing Address _____

City _____ **State** _____ **Zip** _____

Telephone _____

Credit Card Number: _____

Expiration Date (month/year): ____ / ____

3-Digit Verification Code: _____ (See signature area on back of card)

I authorize Mercy Health Plans to charge my credit card on the 15th of each month for the amount of my monthly premium plus a 2% administrative fee.

I authorize a one-time charge to my credit card for \$ _____ premium plus a 2% administration fee.

Signature of Cardholder

Date

* *Note: You may be charged an additional fee for insufficient funds or incorrect banking information*

.....

Attach Voided Check Here