MercyCare, HMO Inc.
PO Box 550
Janesville, WI 53547-0550

CHANGE OF STATUS FORM

Please Print

PHONE (800) 752-3431
FAX (608) 752-3751
EMAIL: mchpenrollment@mhemail.org

GROUP/EMPLOYER NAME				GROUP NUMBER	EFFECTIVE DATE OF CHANGE
SUBSCRIBER LAST NAME	**FIRST**	**M.I.**	**SEX** ☐ M ☐ F	**SOCIAL SECURITY #**	**TODAY'S DATE**

SUBSCRIBER ADDRESS	CITY	ZIP	CHECK IF NEW	HOME PHONE	CHECK IF NEW
			☐		☐

☐ **ADDITION (S)** **OR** ☐ **DELETION (S)**

RELATIONSHIP	LAST NAME	FIRST	M.I.	SOCIAL SECURITY #	DATE OF BIRTH	SEX	PRIMARY CARE PHYSICIAN

PLEASE CHECK REASON FOR CHANGE:

☐ BIRTH OR ADOPTION
☐ MARRIAGE – DATE: _____
☐ DIVORCE
☐ ADDRESS CHANGE
☐ COBRA/CONTINUATION ☐ 18 MONTH ☐ 36 MONTH
☐ EMPLOYEE DISENROLLED
☐ EMPLOYEE INELIGIBLE
☐ EMPLOYEE LAID OFF
☐ DEPENDENT OVER AGE
☐ LEFT EMPLOYMENT
☐ MOVED OUT-OF-AREA
☐ EMPLOYEE DECEASED
☐ DEPENDENT DECEASED
☐ OTHER (please explain) _____
☐ COORDINATION OF BENEFITS CHANGE/OTHER INSURANCE (please explain) _____

NAME CHANGE

FROM: TO:

I hereby apply for amendment of my application. It is mutually agreed as follows: That these changes shall not become effective unless and until accepted; that this application for change in coverage will become part of my original application and will be subject to the terms of agreement(s) in effect with MercyCare HMO, Inc.

_____ SIGNATURE OF SUBSCRIBER

_____ SIGNATURE OF EMPLOYER (Required)

_____ DATE