

Employer Name: _____

Name: _____

Social Security #: _____

ALL AREAS BELOW MUST BE FILLED OUT FOR EACH DEPENDENT OR PROCESSING YOUR APPLICATION WILL BE DELAYED: If dependent has a different last name from the subscriber or is disabled, please attach appropriate documentation from courts or physician.

Social Security #	Last Name First MI	Relationship	Date of Birth MM/DD/YYYY	Sex	Height	Weight	Smoker?	Enrolled in Medicare?	Other Group Coverage?	Taking Medication?
		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	<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	<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	<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	<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	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Check all boxes below for any health conditions for which you or your family members have been diagnosed as having or treated for in the last 5 years:

<p>1. CANCER/TUMOR <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> BASAL CELL <input type="checkbox"/> BREAST <input type="checkbox"/> OVARIAN <input type="checkbox"/> CERVICAL <input type="checkbox"/> PROSTATE <input type="checkbox"/> COLON <input type="checkbox"/> LEUKEMIA <input type="checkbox"/> LYMPHOMA <input type="checkbox"/> MELANOMA <input type="checkbox"/> LIVER <input type="checkbox"/> OTHER _____</p> <p>STAGE _____ DATE of DIAGNOSIS _____ DATE of LAST TREATMENT _____</p> <p>Name of member with condition/diagnosis _____ Related Hospital Stays (admit date & length of stay) _____</p> <p>Related Medications (past/present; dates Rx taken) _____</p> <p>Current/Future Treatments _____</p>
<p>2. HEART/CIRCULATORY <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> ANEURYSM <input type="checkbox"/> ANGIOPLASTY <input type="checkbox"/> ARRHYTHMIA <input type="checkbox"/> BYPASS <input type="checkbox"/> CONGESTIVE HEART FAILURE <input type="checkbox"/> CORONARY HEART DISEASE <input type="checkbox"/> ELEVATED CHOLESTEROL (Last 3 readings: _____) <input type="checkbox"/> HIGH BLOOD PRESSURE (Last 3 readings: _____) <input type="checkbox"/> HEART ATTACK <input type="checkbox"/> MITRAL VALVE PROLAPSE <input type="checkbox"/> PHLEBITIS <input type="checkbox"/> STROKE <input type="checkbox"/> OTHER _____</p> <p>Name of member with condition/diagnosis _____ Related Hospital Stays (admit date & length of stay) _____</p> <p>Related Medications (past/present; dates Rx taken) _____</p> <p>Current/Future Treatments _____</p>
<p>3. BLOOD DISORDER <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> ANEMIA <input type="checkbox"/> HEMOPHILIA <input type="checkbox"/> OTHER _____</p> <p>Name of member with condition/diagnosis _____ Related Hospital Stays (admit date & length of stay) _____</p> <p>Related Medications (past/present; dates Rx taken) _____</p> <p>Current/Future Treatments _____</p>
<p>4. REPRODUCTIVE <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> CURRENT PREGNANCY: Due Date _____ MULTIPLES EXPECTED (# _____) <input type="checkbox"/> PREGNANCY COMPLICATIONS (PAST OR PRESENT) <input type="checkbox"/> ABNORMAL PAP SMEAR <input type="checkbox"/> ENDOMETRIOSIS <input type="checkbox"/> INFERTILITY <input type="checkbox"/> FIBROCYSTIC DISEASE <input type="checkbox"/> OTHER _____</p> <p>Name of member with condition/diagnosis _____ Related Hospital Stays (admit date & length of stay) _____</p> <p>Related Medications (past/present; dates Rx taken) _____</p> <p>Current/Future Treatments _____</p>
<p>5. DIGESTIVE <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> ACID REFLUX <input type="checkbox"/> CROHN'S DISEASE <input type="checkbox"/> DIVERTICULOSIS <input type="checkbox"/> GASTRIC BYPASS <input type="checkbox"/> HEPATITIS B/C <input type="checkbox"/> HIATAL HERNIA <input type="checkbox"/> ULCERATIVE COLITIS / IBS <input type="checkbox"/> GALLBLADDER <input type="checkbox"/> GROWTH HORMONES <input type="checkbox"/> PANCREATITIS <input type="checkbox"/> OTHER _____</p> <p>Name of member with condition/diagnosis _____ Related Hospital Stays (admit date & length of stay) _____</p> <p>Related Medications (past/present; dates Rx taken) _____</p> <p>Current/Future Treatments _____</p>
<p>6. ENDOCRINE <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> GRAVE'S DISEASE <input type="checkbox"/> HYPOTHYROIDISM <input type="checkbox"/> PITUITARY DISORDER <input type="checkbox"/> ADRENAL DISORDER <input type="checkbox"/> DIABETES TYPE I (INSULIN) # of units per day _____ <input type="checkbox"/> DIABETES TYPE II (NON-INSULIN) <input type="checkbox"/> OTHER _____</p> <p>If Diabetes checked, please provide initial date of onset: _____ Fasting Glucose Level: _____ Random Glucose Level: _____</p> <p>Name of member with condition/diagnosis _____ Related Hospital Stays (admit date & length of stay) _____</p> <p>Related Medications (past/present; dates Rx taken) _____</p> <p>Current/Future Treatments _____</p>
<p>7. NERVOUS/BRAIN <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> ALZHEIMER'S DISEASE <input type="checkbox"/> CEREBRAL PALSY <input type="checkbox"/> DEMENTIA <input type="checkbox"/> EPILEPSY/SEIZURES (Date of last Seizure _____) <input type="checkbox"/> PARALYSIS <input type="checkbox"/> PARKINSON'S DISEASE <input type="checkbox"/> MULTIPLE SCLEROSIS <input type="checkbox"/> MIGRAINES <input type="checkbox"/> OTHER _____</p> <p>If Migraines marked, please indicate how many per year: _____ Original onset more than 6-months ago: YES _____ NO _____</p> <p>Name of member with condition/diagnosis _____ Related Hospital Stays (admit date & length of stay) _____</p> <p>Related Medications (past/present; dates Rx taken) _____</p> <p>Current/Future Treatments _____</p>

8. IMMUNE/INFECTIOUS DISEASE <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> HIV <input type="checkbox"/> AIDS <input type="checkbox"/> CHLAMYDIA /GENITAL HERPES/GONORRHEA <input type="checkbox"/> SYPHILIS <input type="checkbox"/> OTHER _____
Name of member with condition/diagnosis _____ Related Hospital Stays (admit date & length of stay) _____ Related Medications (past/present; dates Rx taken) _____ Current/Future Treatments _____	
9. RESPIRATORY /LUNG <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> ALLERGIES (Seasonal/Non-Seasonal) <input type="checkbox"/> ASTHMA <input type="checkbox"/> CHRONIC BRONCHITIS <input type="checkbox"/> CYSTIC FIBROSIS <input type="checkbox"/> EMPHYSEMA <input type="checkbox"/> COPD <input type="checkbox"/> SLEEP APNEA (C-Pap Machine: Yes___ No___) <input type="checkbox"/> TUBERCULOSIS <input type="checkbox"/> OTHER _____
Name of member with condition/diagnosis _____ Related Hospital Stays (admit date & length of stay) _____ Related Medications (past/present; dates Rx taken) _____ Current/Future Treatments _____	
10. EAR/NOSE/THROAT/SKIN <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> CELLULITIS/SKIN ULCER <input type="checkbox"/> CYSTS <input type="checkbox"/> CATARACTS <input type="checkbox"/> CHRONIC EAR INFECTIONS <input type="checkbox"/> PSORIASIS <input type="checkbox"/> GLAUCOMA (Ocular Pressure Reading_____) <input type="checkbox"/> ACOUSTIC NEUROMA <input type="checkbox"/> CHRONIC SINUSITIS <input type="checkbox"/> OTHER _____
Name of member with condition/diagnosis _____ Related Hospital Stays (admit date & length of stay) _____ Related Medications (past/present; dates Rx taken) _____ Current/Future Treatments _____	
11. URINARY/KIDNEY <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> KIDNEY STONES <input type="checkbox"/> CHRONIC URINARY TRACT INFECTIONS <input type="checkbox"/> RENAL FAILURE <input type="checkbox"/> BLADDER DISORDER <input type="checkbox"/> POLYCYSTIC KIDNEY DISEASE <input type="checkbox"/> ENLARGED PROSTATE <input type="checkbox"/> INTERSTITIAL CYSTITIS <input type="checkbox"/> OTHER _____
Name of member with condition/diagnosis _____ Related Hospital Stays (admit date & length of stay) _____ Related Medications (past/present; dates Rx taken) _____ Current/Future Treatments _____	
12. BONES/MUSCLES <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> RHEUMATOID ARTHRITIS <input type="checkbox"/> OSTEOARTHRITIS <input type="checkbox"/> BULGING/HERNIATED DISC <input type="checkbox"/> LUPUS <input type="checkbox"/> CARPAL TUNNEL <input type="checkbox"/> OSTEOPOROSIS <input type="checkbox"/> FIBROMYALGIA <input type="checkbox"/> FRACTURES <input type="checkbox"/> KNEE / HIP REPLACEMENT (Date of Surgery_____) <input type="checkbox"/> SCOLIOSIS <input type="checkbox"/> SPINA BIFIDIA <input type="checkbox"/> MUSCULAR DYSTROPHY <input type="checkbox"/> CHRONIC NECK/BACK PAIN <input type="checkbox"/> OTHER _____
Name of member with condition/diagnosis _____ Related Hospital Stays (admit date & length of stay) _____ Related Medications (past/present; dates Rx taken) _____ Current/Future Treatments _____	
13. MENTAL HEALTH/ SUBSTANCE ABUSE <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> ALCOHOLISM <input type="checkbox"/> ANXIETY DISORDER/MILD DEPRESSION <input type="checkbox"/> ATTENTION DEFICIT DISORDER <input type="checkbox"/> BIPOLAR / MAJOR DEPRESSION <input type="checkbox"/> SUBSTANCE ABUSE <input type="checkbox"/> EATING DISORDER <input type="checkbox"/> SUICIDE ATTEMPT <input type="checkbox"/> COUNSELING <input type="checkbox"/> OTHER _____
Name of member with condition/diagnosis _____ Related Hospital Stays (admit date & length of stay) _____ Related Medications (past/present; dates Rx taken) _____ Current/Future Treatments _____	
14. TRANSPLANT <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> BONE MARROW <input type="checkbox"/> KIDNEY <input type="checkbox"/> LUNG <input type="checkbox"/> HEART <input type="checkbox"/> LIVER <input type="checkbox"/> DISCUSSION ABOUT POSSIBLE FUTURE TRANSPLANT <input type="checkbox"/> OTHER _____
Name of member with condition/diagnosis _____ Related Hospital Stays (admit date & length of stay) _____ Related Medications (past/present; dates Rx taken) _____ Current/Future Treatments _____	
15. OTHER <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> ABNORMAL TEST OR PHYSICAL RESULT <input type="checkbox"/> CONDITION OR DISORDER NOT MENTIONED ABOVE _____
Name of member with condition/diagnosis _____ Related Hospital Stays (admit date & length of stay) _____ Related Medications (past/present; dates Rx taken) _____ Current/Future Treatments _____	

MUST SIGN BELOW

IMPORTANT INFORMATION—PLEASE CAREFULLY READ THE FOLLOWING INFORMATION. IT IS PART OF THE AGREEMENT BETWEEN YOU AND MERCY HEALTH PLANS

Please accept this application for participation in Mercy Health Plans of Missouri, Inc./Mercy Health Plans (collectively, "MHP") for listed family members and myself. I also agree, on behalf of myself and covered family members, to conform to all requirements described in the Agreement/Policy. 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. I understand this application is not in force until approved by MHP. 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. Any changes in eligibility must be reported to MHP immediately.

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself or any of my dependents and/or undersigned spouse, I/we authorize any health care professional or organization to make available to the health plan/insurer and the employer or any of their designees, any and all records or information relating to my family, our medical history or services received for any purpose such as evaluation of this application or a claim, or for any analytical or research purposes. I/we also authorize the use of our Social Security Numbers for purposes of identification. A photocopy of this authorization will be as valid as the original.

Employee Signature

Spouse Signature (if applicable)

Date Signed