Enrollment/Change Form

MVP Health Plan, Inc. / MVP Health Insurance Company / MVP Health Services Corp.
HEADQUARTERS 625 State Street, P.O. Box 2207, Schenectady, NY 12301-2207, 518-370-4793, 1-800-777-4793
LOCAL MARKETING OFFICE: Call 1-800-TALK-MVP and you will be directed to the appropriate marketing office.

1 INFORMATION ABOUT YOURSELF

INSTRUCTIONS TO EMPLOYEE: Please print or type and complete Sections 1 through 5.

Employee Name *(Last, First, Initial, Suffix)* Marital Status ☐ Single ☐ Married

Address City State Zip County

Home Phone Business Phone Email Address

Employer Date Employed ☐ Full Time ☐ Part Time ☐ Retired

Employer Address City State Zip

Do you or any other family members have health insurance ? ☐ Yes ☐ No If yes, by whom?

Spouse's health insurance carrier *(if other than yours)* Coverage level ☐ Individual ☐ Family Spouse's health insurance ID#

Eligible for Medicare? ☐ Yes ☐ No Employee ID# Spouse ID#

Employee ☐ A Effective Date ☐ B Effective Date Spouse ☐ A Effective Date ☐ B Effective Date

2 ENROLLMENT/CHANGE

For address or Primary Care Physician changes, call **1-888-687-6277** or visit **www.mvphealthcare.com.**

A

☐ New Applicant
☐ Name Change
☐ COBRA
☐ Add Dependent
☐ Plan Transfer
☐ Address Change

Reason:

☐ New Hire
☐ Open Enrollment
☐ COBRA/State Continuation
☐ Qualifying Event *(describe)* _____
☐ Other _____

B

☐ Termination
☐ Remove Dependent(s) only *(please specify)*

_____

Reason:

☐ Termination of Employment ☐ Opting for Other Coverage
☐ Moved From Area ☐ Other _____

3 CHOOSE COVERAGE

☐ HMO*
☐ PPO
☐ Indemnity
☐ Dental
☐ POS*
☐ EPO
☐ Healthy NY*
☐ Prescription Drug Only
☐ High Deductible EPO
☐ High Deductible PPO
☐ TriVantage *(choose an option)*:
☐ Active Lifestyles
☐ Family Focus
☐ Healthy Alternatives

**Please choose a Primary Care Physician—for each family member—in Section 4.*

4 INFORMATION ABOUT ALL FAMILY MEMBERS YOU WANT ENROLLED UNDER YOUR PLAN

If you are applying for HMO, POS or Healthy NY coverage, you and each of your dependents must designate your choice of Primary Care Physician in order for MVP to initiate coverage. NOTE: Any dependents over dependent maximum age will require a waiver.

1. Name (First, MI, Last) Relationship to Employee self

☐ Male ☐ Female Date of Birth ___ ___/___ ___/___ ___ Social Security No.___ ___ ___ ___-___ ___ ___ ___-___ ___ ___ ___

Primary Care Physician (PCP) (First, Last) PCP Number

2. Name (First, MI, Last) Relationship to Employee ☐ spouse ☐ partner

☐ Male ☐ Female Date of Birth ___ ___/___ ___/___ ___ Social Security No.___ ___ ___ ___-___ ___ ___ ___-___ ___ ___ ___

Primary Care Physician (PCP) (First, Last) PCP Number

3. Name (First, MI, Last) Relationship to Employee Check all that apply: ☐ Disabled ☐ Current Patient ☐ Full-time Student over 18

☐ Male ☐ Female Date of Birth ___ ___/___ ___/___ ___ Social Security No.___ ___ ___ ___-___ ___ ___ ___-___ ___ ___ ___ *If applicable:* College Name

Primary Care Physician (PCP) (First, Last) PCP Number Expected Graduation Date

4. Name (First, MI, Last) Relationship to Employee Check all that apply: ☐ Disabled ☐ Current Patient ☐ Full-time Student over 18

☐ Male ☐ Female Date of Birth ___ ___/___ ___/___ ___ Social Security No.___ ___ ___ ___-___ ___ ___ ___-___ ___ ___ ___ *If applicable:* College Name

Primary Care Physician (PCP) (First, Last) PCP Number Expected Graduation Date

5 SIGNATURE

I have read and agree to the authorization of the reverse side of this form. Late entrant? ☐ Yes ☐ No

SIGNATURE _____ **DATE** _____

TO BE COMPLETED BY EMPLOYER

Group # Subgroup # Effective Date Product # Product #

Employee Class Employee Dept. (if applicable) Approved by

AUTHORIZATION

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and, in New York, shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

On behalf of myself and any listed dependents, I (we) hereby apply for membership in MVP. I understand that benefits provided under MVP's Healthy NY plan may be subject to preexisting condition limitations. If applicable, a medical questionnaire will be forwarded to you for your completion.

I authorize my employer to deduct from my earnings the necessary contribution, if any, required of me.

I hereby authorize any licensed physician, hospital or other health care provider to furnish MVP with such medical information about myself and my minor eligible dependents listed on the application that may be required to allow MVP to administer my benefits. This authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC.

I hereby certify that the statements made are true and complete to the best of my knowledge and belief.