MVP HEALTH CARE

SCHENECTADY OFFICE

Enrollment/Change Form

MVP Health Plan, Inc.
MVP Health Insurance Company
MVP Health Services Corp.

ACTION REQUESTED:
☐ **Enroll**
☐ **Change**
☐ **Cancel**

TO BE COMPLETED BY EMPLOYER	Group #	Subgroup #	Effective Date	Product ID Number	Product ID Number
Employee Class	Employee Dept. (if applicable)		Approved by	Employer ID #	

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 _____

Phone _____ Employer _____ Date Employed _____ ☐ Active ☐ Retiree

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 **1-800-318-8575** 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 _____
☐ Dependent to 30 _____

Effective Date of Change _____

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

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

Effective Date of Change _____

3 CHOOSE COVERAGE

☐ HMO* ☐ EPO
☐ PPO ☐ Healthy NY*
☐ Indemnity ☐ Prescription Drug Only
☐ Dental ☐ High Deductible EPO
☐ POS* ☐ 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.

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

☐ Male ☐ Female Date of Birth ___ ___/___ ___/___ ___ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

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

2. Name (First, MI, Last) _____ Relationship to Employee ☐ spouse/civil union partner ☐ Domestic Partner

☐ Male ☐ Female Date of Birth ___ ___/___ ___/___ ___ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

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. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___ *If applicable:* College Name _____

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

Eligible for insurance through own employer? ☐ Yes ☐ No Employer _____

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. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___ *If applicable:* College Name _____

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

Eligible for insurance through own employer? ☐ Yes ☐ No Employer _____

For additional dependents, please list on a separate form.

5 SIGNATURE

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

SIGNATURE _____ **DATE** _____

**Applicable to HMO products only. This information will be used to determine eligibility for student out-of-area coverage.*

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. A pre-existing condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month (6) period ending on the enrollment date. We will exclude coverage for health care services during the first twelve (12) months of this Contract that relate to pre-existing conditions.

We will credit to the Covered Person the time he was covered under previous health insurance plans, if the previous coverage was continuous to a date not more than sixty-three (63) days prior to the Enrollment Date of this Contract.

Additionally no pre-existing condition exclusion will be imposed on an "eligible individual" as defined in section 2741(b) of the federal Public Health Service Act, 42 USC §300gg-41(b); nor on those under 19 years of age.

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.