



SCHENECTADY OFFICE

# Enrollment/Change Form

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

**ACTION REQUESTED:**

- Enroll**
- Change**
- Cancel**

<b>TO BE COMPLETED BY EMPLOYER</b>	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  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](http://www.mvphealthcare.com).

**A**  New Applicant **Reason:**  
 Name Change  New Hire  
 COBRA  Open Enrollment  
 Add Dependent  COBRA/State Continuation  
 Plan Transfer  Qualifying Event (describe) \_\_\_\_\_  
 Address Change  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  TriVantage (choose an option):  
 PPO  Healthy NY\*  Active Lifestyles  
 Indemnity  Prescription Drug Only  Family Focus  
 Dental  High Deductible EPO  Healthy Alternatives  
 POS\*  High Deductible PPO  
*\*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 \_\_\_\_\_

## 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.