MVP HEALTH CARE

SCHENECTADY OFFICE

Enrollment/Change Form

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

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

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 _____

B

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

Reason:

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

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 in order for MVP to initiate coverage.

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

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

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** _____