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. ___ ___ ___ - ___ ___ - ___ ___ ___ ___

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. ___ ___ ___ - ___ ___ - ___ ___ ___ ___

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

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).

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.