



# 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](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 \_\_\_\_\_

- 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. 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 \_\_\_\_\_

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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 \_\_\_\_\_

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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 \_\_\_\_\_

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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.