Health Plan Enrollment or Change
for New York State Small Group HMO Plans

Action Requested: ☐ **Enrollment** ☐ **Change** ☐ **Termination** *Please complete both sides of this form.*

To be Completed by Employer *(Include Group Name, Group No., and Applicant Name on page 2)*

Group Name	Group No.	Subgroup No.	Effective Date

Product ID No.	Employee Class

Section 1: Information About Yourself *(please print)*

Applicant Name *(First, Middle Initial, Last)* | Marital Status ☐ Single ☐ Married

Street Address	City	State	Zip Code	County

Email	Home Phone No.	Mobile Phone No.

Coverage Level ☐ Applicant ☐ Applicant and Spouse ☐ Applicant and Dependent(s) ☐ Family

Are you and/or your spouse eligible for Medicare? ☐ **Yes** ☐ **No**

If ***Yes***, provide your Medicare Member ID No(s).
(Yourself) (Spouse, if eligible)

If ***Yes***, provide Medicare Parts A and B Effective Dates
(Yourself) Part A Part B (Spouse) Part A Part B

Section 2: Enrollment/Change/Termination Information

Enrollment or Change *(check all that apply)*

☐ New Applicant ☐ Add Dependent ☐ Name Change
☐ Transfer to Another Plan ☐ Address Change ☐ COBRA

Requested Effective Date

Reason

☐ New Hire (Date of Hire:) ☐ Open Enrollment
☐ Qualifying Event *(explain)*

☐ Other

Termination

☐ Terminate from Plan
☐ Remove Dependent(s) only *(specify name or member ID no.)*

Requested Effective Date

Reason for Termination

☐ Termination of Employment ☐ Opting for Other Coverage
☐ Moved from Service Area
☐ Other

Section 3: Coverage Selection (Enrollments and Changes)

Plan Name (e.g., Gold 2 HDHP)

Optional Selection
☐ Vision

If scanning this form for submission, be sure to scan and return both pages of this form.

Continued on page 2

Group Name *Group No.* *Applicant Name*

Section 4: Information About All Family Members You Want to Enroll in Your Plan *(Complete for Enrollments and Changes)*

Please use a separate form for additional individuals.

1 Applicant ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth *(required)* | Social Security No. *(required)*

Primary Care Physician* *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

2 Name *(First, Middle Initial, Last)* ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth *(required)* | Social Security No. *(required)*

Relationship to Applicant ☐ Spouse ☐ Dependent | Primary Care Physician* *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

3 Name *(First, Middle Initial, Last)* ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth *(required)* | Social Security No. *(required)*

Relationship to Applicant ☐ Dependent | Primary Care Physician* *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

4 Name *(First, Middle Initial, Last)* ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth *(required)* | Social Security No. *(required)*

Relationship to Applicant ☐ Dependent | Primary Care Physician* *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

Section 5: Authorization *(Your signature is required for Enrollments, Changes, or Terminations)*

On behalf of myself and any members of my family for whom I have enrollment authority and have listed on this enrollment form, I (we) hereby apply for membership in MVP. I hereby consent to the release, use, and disclosure of any medical information about me and any members of my family for whom I can give consent:

- By my primary care provider, any other health care provider, or the New York State Department of Health ("NYSDOH") to MVP and any health care providers involved in caring for me or my family, as reasonably necessary for MVP or my health care providers to carry out treatment, payment, or health care operations functions, or other functions permitted by, and in accordance with, applicable laws, regulations, and rules. This may include pharmacy and other medical claims information needed to help manage my care;
- By MVP and any health care providers to NYSDOH and other authorized federal, state, and local agencies for purposes of administering health programs to the extent permitted by, and in accordance with, applicable laws, regulations, and rules; and
- By MVP to my providers or other persons or organizations, as reasonably necessary for MVP or my providers to carry out treatment, payment, or health care operations, or as otherwise and to the extent permitted by, and in accordance with, applicable laws, regulations, and rules.

At any time, I can take away the permission I gave to release information. All I have to do is call the MVP Customer Care Center at the phone number listed on the back of my MVP Member ID card.

I hereby certify that the statements made are true and complete to the best of my knowledge and belief.

Unless otherwise prohibited by law, I consent to the receipt of electronic communications related to my MVP health plan at the email address I provided. I understand that I am entitled to receive paper documents, and that I can set and change my communication preferences at any time by signing in at **mvphealthcare.com** and selecting *Communication Preferences*. I have read and agree to the details outlined in MVP's *Electronic Disclosure*, which is available at **mvphealthcare.com** or by calling MVP at **1-800-TALK-MVP** (1-800-825-5687).

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the state value of the claim for each such violation.

I have read and agree to this authorization.

Signature *Date*

Questions? We're here to help. Call **1-844-865-0250** Visit **mvphealthcare.com** Fax: **518-386-7595**

Return this completed application by mail to **MVP HEALTH CARE 625 STATE ST SCHENECTADY NY 12305-2111**

(Be sure to include both pages when submitting this form)