New Hampshire Enrollment/Change Form

MVP Health Plan of New Hampshire, Inc. / MVP Health Insurance Company of New Hampshire, Inc.
HEADQUARTERS 625 State Street, P.O. Box 2207, Schenectady, NY 12301-2207, 518-370-4793, 1-800-777-4793
LOCAL MARKETING OFFICE: 33 So. Commercial St., Suite 303, Manchester, NH 03101 | **PH** (603) 647-7181 | **FAX** (603) 647-9607

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 and 8.

Employee Name *(Last, First, Initial, Suffix)* Marital Status ☐ Single ☐ Married ☐ Civil Union

Address City State Zip County

Home Phone Business Phone Email Address

Employer Date Employed ☐ Full Time ☐ Part Time ☐ Retired

Employer Address City State Zip

Is your Spouse, Domestic or Civil Union Partner employed? ☐ Yes ☐ No If yes, by whom? Spouse, Domestic or Civil Union Partner's health insurance carrier *(if other than yours)*

Coverage level ☐ Individual ☐ Family Spouse, Domestic or Civil Union Partner's health insurance ID# Effective Date

Eligible for Medicare? ☐ Yes ☐ No Employee ID# Spouse, Domestic or Civil Union Partner ID#

Employee ☐ A Effective Date ☐ B Effective Date ☐ D Effective Date Spouse, Domestic or Civil Union Partner ☐ A Effective Date ☐ B Effective Date ☐ D Effective Date

2 ENROLLMENT/CHANGE

For address or Primary Care Physician changes, call **1-888-687-6277** 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*
- ☐ POS*
- ☐ PPO
- ☐ HealthFirst*
- ☐ EPO
- ☐ Indemnity
- ☐ HDHP/HSA
- ☐ HDHP
- ☐ TriVantage *(choose an option)*:
  - ☐ Active Lifestyles
  - ☐ Family Focus
  - ☐ Healthy Alternatives

**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 HealthFirst coverage, you and each of your dependents must designate your choice of Primary Care Physician. For help, visit MVP's Web site www.mvphealthcare.com or contact MVP Member Services Dept. at 1-888-MVP-MBRS (1-888-687-6277).

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, Domestic or Civil Union 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

NOTE: With the exception of your spouse, domestic or civil union partner, each dependent must be (1) a subscriber's child by blood or by law, who is unmarried and one of the following: (i) Under age 19; (ii) Under age 25 if the child is a full-time enrolled student at an educational institution; or (iii) Under age 26, a resident of New Hampshire, and is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, church plan, or health benefits plan, or entitled to benefits under Title XVIII of the Social Security Act, Public Law 89-97, 42 U.S.C. section 1395 et seq.; or (2) an Adult Disabled Dependent who has submitted a completed Disability Waiver Form. You may download this form from MVP's web site, www.mvphealthcare.com or contact MVP Member Services Department at 1-888-MVP-MBRS (1-888-687-6277) to request the form.

5 OTHER COVERAGE INFORMATION

1. **Indicate plans in force during the last 9 months. Please provide Certificates of Creditable Coverage.**
2. Do you, your spouse, domestic or civil union partner or any named dependent already have existing health coverage with another company? ☐ Yes ☐ No If yes, please complete the questions below.

Policy Holder of other Health Coverage____________________

Policy Holder's Relationship to your Dependent's ____________________ Policy Holder's Month and Day of Birth____________________

Is this insurance Family court ordered? ☐ Yes ☐ No ☐ N/A If Yes, please attach a copy of that section of the court order which pertains to health insurance coverage and complete the questions below.

Do you have physical custody of your dependent(s)? ☐ Yes ☐ No OR Is there joint legal custody? ☐ Yes ☐ No

Where does your dependent(s) reside? ☐ Mother ☐ Father

6 AUTHORIZATION

On behalf of myself and any listed dependents, I (we) hereby apply for membership in MVP. I understand that benefits provided under MVP's plans may be subject to preexisting condition limitations.

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.

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

7 AGREEMENTS

I, the undersigned, agree that all answers in the application: (a) are true and complete to the best of my knowledge and belief and (b) will be relied on to determine insurability and (c) which are incorrect for misleading, may void the application effective the issue date.

No Agent/Producer can: (a) waive or change any receipt; or (b) agree to issue a Certificate of Coverage. I have: (a) read the Agreements section and (b) read and approved the answers as recorded.I hereby represent that the statements made are true and complete to the best of my knowledge and belief.

8 SIGNATURE

I have read and agree to the authorization and agreements above.

SIGNATURE ____________________ **DATE** ____________________