Health Plan Enrollment or Change Request

For New York State Small Group EPO/PPO Plans

Instructions for Completing this Request

Please complete all sections of this Request form and return all pages to MVP Health Care® by mail to:
MVP HEALTH CARE, 625 STATE ST, SCHENECTADY NY 12305-2111.

If you have questions or need help with this Request form, call **1-844-865-0250** or visit **mvphealthcare.com**.

Reason for Request *(select one)*: ☐ **Enrollment** ☐ **Change** ☐ **Termination**

Section 1: Employer Group Information *(To be completed by Employer)*

Group Name	Group No.	Subgroup No.	Effective Date

Employee Class	Product ID No.

Section 2: Applicant Information *(Please include Applicant Name on each page of this Request)*

*(*Required Information)*

Applicant Name* *(First, Middle Initial, Last)*	MVP Member ID No. *(if already an MVP Member)*	Marital Status ☐ **Single** ☐ **Married**

Street Address	City	State	Zip Code	Home Phone No.
				( )

County	Email	Mobile Phone No.
		( )

Section 3: Enrollment/Change/Termination Information

Enrollment(s) or Change(s) *(select all that apply)*

- ☐ **New Enrollment** *(complete all Sections)*
- ☐ **Add Individual(s) to Current Plan** *(complete Sections 3 and 5)*
- ☐ **Name Change** *(new name entered above, complete Sections 3 and 6)*
- ☐ **Address Change** *(new address entered above, complete Sections 3 and 6)*
- ☐ **Transfer to Another Plan** *(complete Sections 3, 4, and 6)*
- ☐ **COBRA** *(complete Sections 3, 4, and 6)*

Requested Effective Date of Enrollment or Change(s)

Reason for Change(s) *(provide explanation)*

- ☐ **New Hire** Date of Hire: ☐ **Open Enrollment**
- ☐ **Qualifying Event**
- ☐ **Other**

Termination(s)

- ☐ **Terminate from Plan** *(complete Sections 3 and 6)*
- ☐ **Remove Individual(s) from Plan** *(complete Sections 3 and 6)*
  Name(s) or MVP Member ID No(s).

Requested Effective Date of Termination

Reason for Termination

- ☐ **Moved Out of Service Area** ☐ **Opting for Other Coverage**
- ☐ **Termination of Employment**
- ☐ **Other**

Group Name *Group No.* *Applicant Name*

Section 4: Choose Your Coverage (Enrollments and Changes to Current Coverage)

Select a Medical Coverage Level: ☐ Applicant ☐ Applicant and Spouse ☐ Applicant and Dependent(s) ☐ Family

Medical Plan Name *(e.g., Gold 2 HDHP)*:

Select an *Optional* Vision Coverage Level: ☐ Applicant ☐ Applicant and Spouse ☐ Applicant and Dependent(s) ☐ Family

You must select a medical plan if you are choosing to add an optional vision plan.

Select an *Optional* Vision Plan: ☐ MVP Vision 1 ☐ MVP Vision 2 ☐ MVP Vision 3

Section 5: Information About All Family Members Enrolling in Your Plan (Enrollments and Changes Only) *(*Required Information)*

Use a separate form for additional individuals.

Applicant Name ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth* | Social Security No.*

Primary Care Provider Name | Are you already a patient of this Provider? ☐ Yes ☐ No | PCP No.

If ***you*** are age 65 or older, are you currently enrolled in Medicare? ☐ **Yes** *(provide the information below)* ☐ **No**

Your (Applicant) **Medicare** Member ID No. | **Your** (Applicant) **Medicare** Part A and Part B Effective Dates **Part A** **Part B**

Spouse Name ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth* | Social Security No.*

Primary Care Provider Name | Already a patient of this Provider? ☐ Yes ☐ No | PCP No.

If ***your spouse*** is age 65 or older, are they currently enrolled in Medicare? ☐ **Yes** *(provide the information below)* ☐ **No**

Spouse's Medicare Member ID No. | **Spouse's Medicare** Part A and Part B Effective Dates **Part A** **Part B**

Dependent Name ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth* | Social Security No.*

Primary Care Provider Name | Already a patient of this Provider? ☐ Yes ☐ No | PCP No.

Dependent Name ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth* | Social Security No.*

Primary Care Provider Name | Already a patient of this Provider? ☐ Yes ☐ No | PCP No.

Dependent Name ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth* | Social Security No.*

Primary Care Provider Name | Already a patient of this Provider? ☐ Yes ☐ No | PCP No.

Group Name	*Group No.*	*Applicant Name*

Section 6: Authorization

Your signature is required for all enrollments, changes, and terminations.

I hereby apply for membership in MVP Health Care ("MVP") and 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 number listed on the back of my MVP Member ID card.

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 to my MVP online member account at **my.mvphealthcare.com** and selecting *Communication Preferences*.

☐ By checking this box, I attest that I have read and agree to the details outlined in the MVP *Electronic Communications Disclosure*, which is available at **mvphealthcare.com/privacy-notices** 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

I have read and agree to this authorization, and I certify that the statements made are true and complete to the best of my knowledge and belief.

Applicant Signature *Signature Date*