

Health Plan Enrollment or Change

for New York State Student Health Plans



Action Requested: Enrollment Change Termination

Please complete both pages of this form.

To be Completed by School

School Name	Group No.
Effective Date	Approved By

Section 1: Information About Yourself (please include Student Applicant Name on page 2)

Student Applicant Name (First, Middle Initial, Last)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary	Date of Birth (MM/DD/YYYY)	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
Street Address	City	State	Zip Code
County	Email	Phone No.	
School Name	Student ID No.	Mobile Phone No.	

Section 2: Enrollment/Change/Termination Information

Enrollment or Change (check all that apply)

New Student Applicant Name Change Address Change

Requested Effective Date of Enrollment or Change _____

Reason for Enrollment or Change (explain)

Qualifying Event _____

Other _____

Termination

Terminate from Plan

Requested Effective Date of Termination _____

Reason for Termination

Moved from Service Area Opting for Other Coverage

Other _____

Section 3: Authorization (Your signature is required for Enrollment, Changes, or Terminations)

I 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, 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.

Continued on page 2

Student Applicant Name

Section 3 continued from page 1

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** (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 state value of the claim for each violation.

I have read and agree to this authorization.

Signature

Date

Questions? We're here to help.  Call **1-800-TALK-MVP** (825-5687)  Or visit **mvphealthcare.com**

Return this completed application by mail to **MVP HEALTH CARE, PO BOX 2207, SCHENECTADY NY 12301-2207**
(Be sure to include both pages of the form)