Today's Date: ___________________________

Subscriber Name: ____

Disabled Dependent's Name (confirm): ____

City: __________________________________ State: ________________ Zip: ____________

Dear Subscriber,

MVP has been notified of your request to cover your disabled dependent under your contract.

In order for this dependent to continue coverage, please complete the following information below marked, "TO BE COMPLETED BY THE SUBSCRIBER." The member's Primary Care Physician should complete the separate form marked, "TO BE COMPLETED BY THE PRIMARY CARE PHYSICIAN – Disability Eligibility Determination Form" (also available on MVP's Web site) If this information is not received within 30 days, your dependent may be disenrolled from your policy.

If you have any questions, please call the Customer Care Center at **1-888-MVP-MBRS** (**1-888-687-6277**). Representatives are available Monday – Friday from 8 am – 8 pm and Saturday from 8 am – 4 pm Eastern Time. TTY users may call **1-800-662-1220**.

TO BE COMPLETED BY THE SUBSCRIBER

1. Does your dependent receive social security income for this disability? □ Yes □ No

2. Does your dependent have other insurance coverage, such as Medicare or Medicaid, for this disability? □ Yes □ No

3. Is/was your dependent employed? □ Yes □ No If yes, number of hour per week? ___

4. Name of Primary Care Physician: ____

   Address of Primary Care Physician: ____

   Phone number of Primary Care Physician: (_____)_______-___________

Sincerely,

The MVP Customer Care Center Team

MVP Health Care 625 State Street / P.O. Box 2207 / Schenectady, NY 12301-2207 / 518-370-4793 / **www.mvphealthcare.com**