VERMONT ENROLLMENT/CHANGE FORM

ACTION REQUESTED:
☐ Enroll
☐ Change
☐ Cancel

VERMONT
66 Knight Lane
Williston, VT 05495
(802) 264-6500

TO BE COMPLETED BY EMPLOYER	Group #	Subgroup #	Effective Date	Product ID #	Product ID #
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.

Employee Name *(First, MI, Last)* Marital Status ☐ Single ☐ Married

Address City State Zip County

Phone Email Address

Do you or any other family members have health insurance? ☐ Yes ☐ No If yes, by whom? Spouse's health insurance carrier *(if other than yours)* Spouse's health insurance ID#

Coverage level ☐ Subscriber ☐ Subscriber & Spouse ☐ Subscriber & Dependents ☐ Family

Eligible for Medicare? ☐ Yes ☐ No Member ID# Spouse/Dependent ID#

Member ☐ A Effective Date ☐ B Effective Date Spouse ☐ A Effective Date ☐ B Effective Date

2. ENROLLMENT/CHANGE

A. ☐ New Applicant ☐ Add Dependent
☐ Name Change ☐ Plan Transfer
☐ COBRA ☐ Address Change

REASON:
☐ New Hire
☐ Open Enrollment
☐ COBRA/State Continuation
☐ Qualifying Event *(describe)* ____________________
☐ Other____________________

Effective Date of Change____________________

B. ☐ Termination ☐ Remove Dependent(s) only *(please specify)*____________________

REASON:
☐ Termination of Employment ☐ Opting for Other Coverage
☐ Moved From Area ☐ Other____________________

Effective Date of Change____________________

3. CHOOSE COVERAGE

☐ Standard ☐ Non-Standard ☐ Metal Level ____________________Metal # (if applicable)____________________Product ID____________________

Other____________________

☐ HMO* ☐ PPO ☐ Dental ☐ Other ☐ EPO ☐ Prescription Drug Only ☐ High Deductible EPO ☐ High Deductible PPO

☐ TriVantage *(choose an option)*: ☐ Active Lifestyles ☐ Family Focus ☐ Healthy Alternatives

4. INFORMATION ABOUT ALL FAMILY MEMBERS YOU WANT ENROLLED UNDER YOUR PLAN

*You and each of your dependents must designate your choice of Primary Care Physician. For help, visit MVP's website **www.mvphealthcare.com** or contact the MVP Customer Care Center. For additional dependents, please list on a separate form.

1. Self

☐ Male ☐ Female Age__________ Date of Birth ____ ____ / ____ ____ /____ ____ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Primary Care Physician (PCP) *(First, Last)* PCP ID#

2. Name *(First, MI, Last)* Relationship to Subscriber

☐ Male ☐ Female Age__________ Date of Birth ____ ____ / ____ ____ /____ ____ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Primary Care Physician (PCP) *(First, Last)* PCP ID#

3. Name *(First, MI, Last)* Relationship to Subscriber

☐ Male ☐ Female Age__________ Date of Birth ____ ____ / ____ ____ /____ ____ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Primary Care Physician (PCP) *(First, Last)* PCP ID#

4. Name *(First, MI, Last)* Relationship to Subscriber

☐ Male ☐ Female Age__________ Date of Birth ____ ____ / ____ ____ /____ ____ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Primary Care Physician (PCP) *(First, Last)* PCP ID#

5. SIGNATURE

I have read and agree to the authorization of the reverse side of this form.

SIGNATURE ____ **DATE** ____________________

By including an email address on this Enrollment/Change Form, you agree to accept electronic communication unless otherwise required by law.

6. AUTHORIZATION

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, in New York, shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. On behalf of myself and any listed dependents, I (we) hereby apply for membership in MVP.

I hereby consent to the release of any medical, health and/or payment information (including without limitation pharmacy and claims information) about me and my minor eligible dependents by any licensed physician, hospital, other health care provider, or authorized federal, state or local agencies to MVP and any health care providers involved in caring for me or my minor eligible dependents, as reasonably necessary to allow MVP to administer my benefits or for MVP or my health care providers to carry out treatment, payment, or health care operations functions, to the extent permitted by law. I also agree that the information released for treatment, payment and health care operations may include HIV, STD, mental health or alcohol and substance abuse information about me and my minor eligible dependents to the extent permitted by law, until I revoke this consent.

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