Dental Plan Enrollment or Change
for New York Individuals

Action Requested: ☐ **Enrollment** ☐ **Change** ☐ **Cancellation**

Please complete both sides of this form.

Section 1: Information About Yourself *(please include Employe Name and Group No. on page 2)*

Employee Name *(First, Middle Initial, Last)* | Marital Status ☐ Single ☐ Married

Street Address | City | State | Zip Code | County

Email | Phone ( )

Coverage Level ☐ Subscriber ☐ Subscriber and Spouse ☐ Subscriber and Dependent(s) ☐ Family

Are you and/or your spouse eligible for Medicare? ☐ Yes ☐ No | If ***Yes***, provide your Medicare Member ID No(s). (Yourself) (Spouse, if eligible)

If ***Yes***, provide Medicare Parts A and B Effective Dates.
(Yourself) Part A Part B (Spouse) Part A Part B

Section 2: Enrollment/Change/Termination Information

Group No. | Sub-Group No.

Enrollment or Change *(check all that apply)*

☐ New Applicant ☐ Add Dependant ☐ Name Change
☐ Transfer to Another Plan ☐ Address Change

Requested Effective Date

Reason

☐ Qualifying Event *(explain)*

☐ Other

Termination

☐ Terminate from Plan
☐ Remove Dependant(s) only *(specify name or member ID no.)*

Requested Effective Date

Reason for Termination

☐ Opting for Other Coverage ☐ Moved from Service Area
☐ Other

Section 3: Choose Your Coverage (Enrollments and Changes)

☐ MVP Dental for Kids ☐ MVP Dental PPO for Adults ☐ MVP Dental PPO for Families ☐ Delta Dental PPO Pediatric Basic Plan

Need help selecting a dental plan? Visit **mvphealthcare.com** or call **1-800-TALK-MVP** to speak with an MVP Customer Care Representative.

Section 4: Information About All Family Members You Want to Enroll in Your Plan (Enrollments and Changes)

Please use a separate form for additional individuals.

1 Subscriber/Applicant ☐ Male ☐ Female | Age | Date of Birth | Social Security No. ***(required)***

2 Name *(First, Middle Initial, Last)* | Relationship to Subscriber/Applicant ☐ Spouse ☐ Dependent

☐ Male ☐ Female | Age | Date of Birth | Social Security No. ***(required)***

3 Name *(First, Middle Initial, Last)* | Relationship to Subscriber/Applicant ☐ Dependent

☐ Male ☐ Female | Age | Date of Birth | Social Security No. ***(required)***

Continued on page 2

Employee Name | *Group No.*

4 Name *(First, Middle Initial, Last)* | Relationship to Subscriber/Applicant ☐ Dependent

☐ Male ☐ Female | Age | Date of Birth | Social Security No. ***(required)***

5 Name *(First, Middle Initial, Last)* | Relationship to Subscriber/Applicant ☐ Dependent

☐ Male ☐ Female | Age | Date of Birth | Social Security No. ***(required)***

6 Name *(First, Middle Initial, Last)* | Relationship to Subscriber/Applicant ☐ Dependent

☐ Male ☐ Female | Age | Date of Birth | Social Security No. ***(required)***

Section 5: Authorization *(Your signature is requried for Enrollment, Changes, or Terminations)*

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 $5,000 and the stated value of the claim for each such violation.

On behalf of myself and any individuals listed on this Section 4 of this applications, I 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 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, 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 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.

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

I have read and agree to this authorization.

Signature | Date

Section 6: Broker Information *(complete if a broker assisted with completing this application)*

Broker Name | Broker Email | Phone Number ( )

Agency Name | Agency Address | MVP Agency No.

Return this completed application by mail to:

MVP HEALTH CARE
625 STATE ST PO BOX 2207
SCHENECTADY NY 12301-2207

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