

Health Plan Enrollment or Change

for New York State Large Group Plans



Action Requested: Enrollment Change Cancellation

Please complete both sides of this form.

To be Completed by Employer (please include the Group Name and Group No. on page 2)

Group Name		Group No.	Subgroup No.	Effective Date
Product ID No.	Product ID No.	Employee Class	Employee Dept. (if applicable)	Approved By

Section 1: Information About Yourself (please print)

Employee Name (First, Middle Initial, Last) _____ Marital Status
 Single Married

Street Address _____ City _____ State _____ Zip Code _____

County _____ Phone (____) _____ Email _____

Do you or any family members have health insurance? Yes No If Yes, with whom? (Name of Carrier) _____

Spouse's Health Insurance Carrier (if other than yours) _____ Spouse's Health Insurance ID No. (if carrier is different than yours) _____

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

Enrollment or Change (check all that apply)

- New Applicant Add Dependant Name Change
 Transfer to Another Plan Address Change COBRA

Requested Effective Date _____

Reason

- New Hire (Date of Hire: _____) Open Enrollment
 COBRA/State Continuation
 Qualifying Event (explain) _____

 Other _____

Termination

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

Requested Effective Date _____

Reason for Termination

- Termination of Employment Opting for Other Coverage
 Moved from Service Area
 Other _____

Section 3: Choose Your Coverage (Enrollments and Changes)

HMO PPO POS EPO High Deductible EPO High Deductible PPO Dental

HMO Health Maintenance Organization plan PPO Preferred Provider Organization plan POS Point of Service plan EPO Exclusive Provider Organization plan

... If scanning this form for submission, be sure to scan and return both sides.

Continued on page 2

Group Name	Group No.	Employee Name
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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		<input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date of Birth	Social Security No. <i>(required)</i>
Primary Care Physician* <i>(First, Last)</i>			Are you already a patient of this physician?		PCP No.
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
2 Name <i>(First, Middle Initial, Last)</i>				Relationship to Subscriber/Applicant	
				<input type="checkbox"/> Spouse <input type="checkbox"/> Dependent	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date of Birth	Social Security No. <i>(required)</i>		
Primary Care Physician* <i>(First, Last)</i>			Already a patient of this physician?		PCP No.
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
3 Name <i>(First, Middle Initial, Last)</i>				Relationship to Subscriber/Applicant	
				<input type="checkbox"/> Dependent	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date of Birth	Social Security No. <i>(required)</i>		
Primary Care Physician* <i>(First, Last)</i>			Already a patient of this physician?		PCP No.
			<input type="checkbox"/> Yes <input type="checkbox"/> No		
4 Name <i>(First, Middle Initial, Last)</i>				Relationship to Subscriber/Applicant	
				<input type="checkbox"/> Dependent	
<input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date of Birth	Social Security No. <i>(required)</i>		
Primary Care Physician* <i>(First, Last)</i>			Already a patient of this physician?		PCP No.
			<input type="checkbox"/> Yes <input type="checkbox"/> No		

*** For HMO and POS plan applicants**, you (Applicant) and each individual listed below must designate a choice of Primary Care Physician (PCP). To search for doctors in our network, visit mvphealthcare.com and select *Find a Doctor*, or contact the MVP Customer Care Center at **1-888-687-6277** for assistance.

Section 5: Authorization (Your signature is required 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