

Health Plan Enrollment or Change

for New York State Small 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 <input type="checkbox"/> Single <input type="checkbox"/> Married	
Street Address		City	State	Zip Code
County	Phone ()	Email		
Do you or any family members have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, with whom?		
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 Dependiant Name Change
 Transfer to Another Plan Address Change COBRA

Requested Effective Date _____

Reason

New Hire (Date of Hire: _____) Open Enrollment
 Qualifying Event (explain) _____

 Other _____

Termination

Terminate from Plan
 Remove Dependiant(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)

Standard Non-Standard Metal Level _____ Metal No. (if applicable) _____ Healthy NY

Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a NY State of Health Marketplace-certified, stand-alone dental plan offered outside of the NY State of Health Marketplace for every person age 18 and under listed in Section 4 of this application, as required by the Affordable Care Act? Yes No

If **Yes**, please provide the name of the company issuing the stand-alone dental coverage. _____

If **No**, MVP will provide you coverage of the pediatric dental essential health benefit (select one), as required by the Affordable Care Act.
 MVP Dental for Kids MVP Dental PPO Delta Dental PPO

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

Primary Care Physician* *(First, Last)* _____ Are you already a patient of this physician? PCP No. _____
 Yes No

If you are age 18 or under, do you have pediatric dental essential health benefit coverage? Yes No If **Yes**, with whom? _____ If **No**, MVP will provide this coverage to you.

2 Name *(First, Middle Initial, Last)* _____ Relationship to Subscriber/Applicant _____
 Male Female Age _____ Date of Birth _____ Social Security No. *(required)* _____
 Spouse Dependent

Primary Care Physician* *(First, Last)* _____ Already a patient of this physician? PCP No. _____
 Yes No

If this person is age 18 or under, do you have pediatric dental essential health benefit coverage for him/her? Yes No If **Yes**, with whom? _____ If **No**, MVP will provide this coverage to him/her.

3 Name *(First, Middle Initial, Last)* _____ Relationship to Subscriber/Applicant _____
 Male Female Age _____ Date of Birth _____ Social Security No. *(required)* _____
 Dependent

Primary Care Physician* *(First, Last)* _____ Already a patient of this physician? PCP No. _____
 Yes No

If this person is age 18 or under, do you have pediatric dental essential health benefit coverage for him/her? Yes No If **Yes**, with whom? _____ If **No**, MVP will provide this coverage to him/her.

4 Name *(First, Middle Initial, Last)* _____ Relationship to Subscriber/Applicant _____
 Male Female Age _____ Date of Birth _____ Social Security No. *(required)* _____
 Dependent

Primary Care Physician* *(First, Last)* _____ Already a patient of this physician? PCP No. _____
 Yes No

If this person is age 18 or under, do you have pediatric dental essential health benefit coverage for him/her? Yes No If **Yes**, with whom? _____ If **No**, MVP will provide this coverage to him/her.

***For Healthy NY 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 _____