Health Plan Enrollment or Change
for Vermont Full-Cost Individual Direct Plans

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

Please complete both sides of this form.

Section 1: Information About Yourself *(please print)*

Applicant 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/Dependent)

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 Dependent
☐ Name Change ☐ Transfer to Another Plan
☐ Address Change

Requested Effective Date

Reason *(explain)*

☐ Qualifying Event

☐ Other

Termination

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

Requested Effective Date

Reason for Termination

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

Note: Effective dates are based on date of receipt at MVP.

Section 3: Choose Your Coverage (Enrollments and Changes)

☐ Standard ☐ Non-Standard ☐ Metal Level ________ **Metal No.** (if applicable) ________

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

You (Subscriber/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.

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? ☐ Yes ☐ No | PCP No.

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

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

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

Continued on page 2

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

Applicant Name

3 Name *(First, Middle Initial, Last)*

Relationship to Subscriber/Applicant
☐ Dependent

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

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

4 Name *(First, Middle Initial, Last)*

Relationship to Subscriber/Applicant
☐ Dependent

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

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

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

Note: Vermont residents who do not receive Advanced Premium Tax Credit (APTC) or Vermont Premium Assistance (VPA) from the State of Vermont are now able to purchase an Individual plan directly through MVP Heath Care. You can determine if you are eligible for these subsidies by visiting **healthconnect.vermont.gov** and selecting *Try Our Decisions Tools*. Or vising **mvphealthcare.com** and using the Subsidy Calculator. If you are eligible, and want to enroll utilizing a subsidy (APTC or VPA), you will need to enroll through the Vermont Health Connect website. If you are not eligible, or eligible but choose to enroll without using any APTC or VPA subsidies, you can enroll directly with MVP Health Care.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. By submitting this enrollment form and personal information, I confirm that I am the policy holder and authorized to make this decision. I understand that if I enroll directly with MVP, I give up my rights to any tax credits or subsidies. I authorize MVP to submit a cancellation to Vermont Health Connect for any On-Exchange coverage I may be enrolled in through Vermont Health Connect.

Only plans purchased through Vermont Health Connect are eligible for subsidies from the government including advanced premium tax credits (APTC) or cost-sharing reductions (CSR). I understand that I am enrolling in a plan that is ***not*** eligible for APTC, CSR, or any financial assistance from the government. I understand that the subsidy calculation at **mvphealthcare.com** is an estimation and not an official determination of eligibility and that it is my responsibility to confirm my official eligibility for subsidies on the Vermont Health Connect website.

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.

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

Return this completed application by mail to:

MVP HEALTH CARE
62 MERCHANTS ROW
WILLISTON VT 05495-4476

(Be sure to return both pages of the form).