Medicare Advantage Health Plans Enrollment Application & Part D Application
EMPLOYER GROUP

By completing this enrollment application, I agree to the following:

MVP is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. **I can be in only one Medicare Advantage plan at a time and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare Advantage health plan.**

It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: Annual Enrollment Period from October 15 – December 7); or through my employer group.

MVP Health Plan, Inc. serves a specific service area. If I move out of the area that MVP serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of MVP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage (contract) from MVP when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.

I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border.

I understand that beginning on the date MVP coverage begins, I must get all of my health care from MVP, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by MVP and other services contained in my MVP Evidence of Coverage document (also know as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR MVP WILL PAY FOR THESE SERVICES.**

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with MVP, he/she may be paid based on my enrollment in MVP.

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Please complete both pages.
Complete one enrollment form per applicant.

Step 1: Plan enrollment selection for employer group or union members

Employer or union name____Group # ______________

Please check which employer group plan you are enrolling in:

☐ Preferred Gold HMO-POS **with** MVP Part D Prescription Drug

☐ GoldAnywhere PPO **with** MVP Part D Prescription Drug

☐ USA Care PPO **with** MVP Part D Prescription Drug

Date coverage should begin: _____/ _____/ _____

Step 2: Member information

LAST Name ____________________________FIRST Name ____________________Mid. Init. _____

Permanent Residence **(Home)** Street Address *(P.O. Box is not allowed)* ____________________________

____

City ________________________________State________ZIP Code _______County ______________

Home Phone Number ( ) _______________ Date of Birth _____ / _____ / _____ Sex: ☐ M ☐ F

Mailing Address *(only if different from your home address)*

Street Address____

City____State __________ZIP Code _____________

Email Address ____

Step 3: Medicare card information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card, OR
- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Medicare Health Insurance

Name ____Medicare Claim # _________________

Is entitled to: Hospital (Part A) ____ / ____ / ____ Medical (Part B) ____ / ____ / ____

Step 4: Primary Care Physician (PCP) – not required for GoldAnywhere PPO or USA Care PPO plans

Primary Care Physician *(full name required)*____

Existing patient? ☐ Yes ☐ No

Step 5: Please read and answer these important questions

1. Are you the retiree? ☐ Yes ☐ No
   If yes, retirement date *(month/day/year)* ____________ If no, name of retiree ______________________
2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No
   If yes, name of spouse ____
   Names of dependents ____
3. Do you or your spouse work? ☐ Yes ☐ No
4. Do you have End Stage Renal Disease (ESRD)? ☐ Yes ☐ No
   If you have had a successful kidney transplant and/or you don't need regular dialysis any more, please attach a note or records from your doctor showing you have had a successful kidney transplant or you don't need dialysis, otherwise we may need to contact you to obtain additional information.
5. Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits, EPIC (in New York) or V-Pharm (in Vermont).
   Will you have other prescription drug coverage in addition to MVP? ☐ Yes ☐ No
   If yes, refer to the ID card for your other drug coverage for the following information:
   Name of other coverage ____
   Effective date ____
   Rx ID # ______________________ Rx Group # ______________________
   Rx BIN # ______________________ Rx PCN ______________________
6. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No
   If "yes," please provide the following information:
   Name of institution ______________________ Phone number ______________
   Address of institution (number and street) ______________________________

Step 6: Signature and Authorization

Release of information: By joining this Medicare health plan, I acknowledge that the Medicare health plan will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that MVP will release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes which follow all applicable Federal statutes and regulations. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above) this signature certifies that:
1) This person is authorized under State law to complete this enrollment, and
2) Documentation of this authority is available upon request from Medicare.

PLEASE SIGN BELOW

Signature ______________________________ Today's date ________________

If you are the authorized representative, you must sign above and provide the following information:

Name ____

Address ____

Phone number ________________ Relationship to enrollee ______________________

Please contact MVP if you need this information explained to you in another language, or provided in a different format (Braille).

Our office hours are:

Monday – Friday, 8 am – 8 pm Eastern Time

From October 1 – February 14,

representatives are available every day from 8 am – 8 pm

1-800-324-3899

TTY: 1-800-662-1220

MVP Health Plan, Inc. is an HMO-POS/PPO/MSA organization with a Medicare contract. Enrollment in MVP Health Plan depends on contract renewal. This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premiums and/or copayments/coinsurance may change on January 1 of each year. You must continue to pay your Medicare Part B premium. The Formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

For Office Use Only

Previous ID #______________________________

Name of staff member/agent/broker (if assisted in enrollment):____________________

Agent License # ______________________________