Health Plan Enrollment or Change
for Healthy NY Small Group Plans

Action Requested: ☐ **Enrollment** ☐ **Change** ☐ **Termination** ***Please complete all pages of this form.***

To be Completed by Employer *(Include Group Name, Group No., and Applicant Name on page 2)*

Group Name	Group No.	Subgroup No.	Effective Date

Product ID No.	Employee Class	Employee Dept. *(if applicable)*	Approved By

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

Applicant 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?

Spouse's Health Insurance Carrier *(if carrier is different than Applicant's)*

Spouse's Health Insurance ID No. *(if carrier is different than Applicant's)*

Is Applicant and/or the spouse eligible for Medicare? ☐ **Yes** ☐ **No** If ***Yes***, provide the Medicare Member ID No(s). Applicant Spouse (if eligible)

If ***Yes***, provide Medicare Parts A and B Effective Dates

Applicant 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 ☐ COBRA

Requested Effective Date

Reason

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

☐ Other

Termination

☐ Terminate from Plan
☐ Remove Dependent(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

If scanning this form for submission, be sure to scan and return all pages of this form.

Continued on page 2

Group Name *Group No.* *Applicant Name*

Section 3: Coverage Selection (Enrollments and Changes)

Medical Coverage Level ☐ Applicant ☐ Applicant and Spouse ☐ Applicant and Dependent(s) ☐ Family

Optional Vision Coverage Level ☐ Applicant ☐ Applicant and Spouse ☐ Applicant and Dependent(s) ☐ Family
Vision coverage level must be equal to or less than medical coverage.

Optional Vision Plan (select one) ☐ MVP Vision 1 ☐ MVP Vision 2 ☐ MVP Vision 3

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 NY State of Health Marketplace, 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® for Families** ☐ **Delta Dental PPO**

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

Please use a separate form for additional individuals.

1 Applicant ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth | Social Security No. *(required)*

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

2 Name *(First, Middle Initial, Last)* ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth | Social Security No. *(required)*

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

3 Name *(First, Middle Initial, Last)* ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth | Social Security No. *(required)*

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

4 Name *(First, Middle Initial, Last)* ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth | Social Security No. *(required)*

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

* The Applicant and each individual listed above must designate a choice of Primary Care Physician (PCP). To search for doctors in the MVP provider network, visit **mvphealthcare.com/findadoctor** or contact the MVP Small Business & Individual Service Unit at **1-844-865-0250** for assistance.

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Group Name *Group No.* *Applicant Name*

Section 5: Authorization *(Your signature is required for Enrollments, Changes, or Terminations)*

On behalf of myself and any members of my family for whom I have enrollment authority and have listed on this enrollment form, I (we) hereby apply for membership in MVP. I hereby consent to the release, use, and disclosure of any medical information about me and any members of my family for whom I can give consent:

- By my primary care provider, any other health care provider, or the New York State Department of Health ("NYSDOH") to MVP and any health care providers involved in caring for me or my family, as reasonably necessary for MVP or my health care providers to carry out treatment, payment, or health care operations functions, or other functions permitted by, and in accordance with, applicable laws, regulations, and rules. This may include pharmacy and other medical claims information needed to help manage my care;
- By MVP and any health care providers to NYSDOH and other authorized federal, state, and local agencies for purposes of administering health programs to the extent permitted by, and in accordance with, applicable laws, regulations, and rules; and
- By MVP to my providers or other persons or organizations, as reasonably necessary for MVP or my providers to carry out treatment, payment, or health care operations, or as otherwise and to the extent permitted by, and in accordance with, applicable laws, regulations, and rules.

At any time, I can take away the permission I gave to release information. All I have to do is call the MVP Customer Care Center at the phone number listed on the back of my MVP Member ID card.

I hereby certify that the statements made are true and complete to the best of my knowledge and belief.

Unless otherwise prohibited by law, I consent to the receipt of electronic communications related to my MVP health plan at the email address I provided.

I understand that I am entitled to receive paper documents, and that I can set and change my communication preferences at any time by signing in at **mvphealthcare.com** and selecting *Communication Preferences*. I have read and agree to the details outlined in MVP's *Electronic Disclosure*, which is available at **mvphealthcare.com** or by calling MVP at **1-800-TALK-MVP** (1-800-825-5687).

☐ Yes ☐ No

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 a civil penalty not to exceed five thousand dollars and the state value of the claim for each violation.

I have read and agree to this authorization.

Signature *Date*

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