



Enrollment/Change Form

MVP Health Plan, Inc. / MVP Health Insurance Company / MVP Health Services Corp.
HEADQUARTERS 625 State Street, P.O. Box 2207, Schenectady, NY 12301-2207, 518-370-4793, 1-800-777-4793
LOCAL MARKETING OFFICE: Call 1-800-TALK-MVP and you will be directed to the appropriate marketing office.

1 INFORMATION ABOUT YOURSELF INSTRUCTIONS TO EMPLOYEE: Please print or type and complete Sections 1 through 5.

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

Address _____ City _____ State _____ Zip _____ County _____

Home Phone _____ Business Phone _____ Email Address _____

Employer _____ Date Employed _____ Full Time Part Time Retired

Employer Address _____ City _____ State _____ Zip _____

Do you or any other family members have health insurance? Yes No If yes, by whom? _____

Spouse's health insurance carrier (if other than yours) _____ Coverage level Individual Family Spouse's health insurance ID# _____

Eligible for Medicare? Yes No Employee ID# _____ Spouse ID# _____

Employee A Effective Date _____ B Effective Date _____ Spouse A Effective Date _____ B Effective Date _____

2 ENROLLMENT/CHANGE For address or Primary Care Physician changes, call 1-888-687-6277 or visit www.mvphealthcare.com.

- A** New Applicant **Reason:**
- Name Change New Hire
- COBRA Open Enrollment
- Add Dependent COBRA/State Continuation
- Plan Transfer Qualifying Event (describe) _____
- Address Change Other _____

- B** Termination
- Remove Dependent(s) only (please specify) _____
- Reason:**
- Termination of Employment Opting for Other Coverage
- Moved From Area Other _____

3 CHOOSE COVERAGE

- HMO* Healthy NY* TriVantage (choose an option):
- PPO Prescription Drug Only Active Lifestyles
- Indemnity High Deductible EPO Family Focus
- Dental High Deductible PPO Healthy Alternatives
- POS*
- EPO

*Please choose a Primary Care Physician—for each family member—in Section 4.

4 INFORMATION ABOUT ALL FAMILY MEMBERS YOU WANT ENROLLED UNDER YOUR PLAN

If you are applying for HMO, POS or Healthy NY coverage, you and each of your dependents must designate your choice of Primary Care Physician in order for MVP to initiate coverage. NOTE: Any dependents over dependent maximum age will require a waiver.

1. Name (First, MI, Last) _____ Relationship to Employee self

Male Female Date of Birth ____/____/____ Social Security No. _____

Primary Care Physician (PCP) (First, Last) _____ PCP Number _____

2. Name (First, MI, Last) _____ Relationship to Employee spouse partner

Male Female Date of Birth ____/____/____ Social Security No. _____

Primary Care Physician (PCP) (First, Last) _____ PCP Number _____

3. Name (First, MI, Last) _____ Relationship to Employee _____ Check all that apply: Disabled Current Patient Full-time Student over 18

Male Female Date of Birth ____/____/____ Social Security No. _____ If applicable: College Name _____

Primary Care Physician (PCP) (First, Last) _____ PCP Number _____ Expected Graduation Date _____

4. Name (First, MI, Last) _____ Relationship to Employee _____ Check all that apply: Disabled Current Patient Full-time Student over 18

Male Female Date of Birth ____/____/____ Social Security No. _____ If applicable: College Name _____

Primary Care Physician (PCP) (First, Last) _____ PCP Number _____ Expected Graduation Date _____

5 SIGNATURE

I have read and agree to the authorization of the reverse side of this form.

Late entrant? Yes No

SIGNATURE _____ DATE _____

TO BE COMPLETED BY EMPLOYER		Group #	Subgroup #	Effective Date	Product #	Product #
Employee Class	Employee Dept. (if applicable)			Approved by		



MVP Health Plan, Inc.
 MVP Health Insurance Company
 MVP Health Services Corp.
 625 State Street
 Schenectady, NY 12305

Small Group Application

1 Section One Group Information

Company Name _____

Address _____

SIC Code _____

City _____

State _____ Zip _____ County _____

Telephone No. () _____ Fax No. () _____

HBA Name _____

Title _____

Telephone No. () _____ Fax No. () _____

Email _____

Additional Office Locations _____

- Type of Group: Employer Group or Employer Trust
 Association or Chamber
 Multiple Employer Trust _____
 Taft Hartley Trust
 Labor Union
 Member of Controlled Group or Corporation

Provide description of Group (this description must address type of business or association, years in existence, present ownership)

2 Section Two Billing Information

Billing Statement to be sent to (If different from HBA above) _____

Address (If different from above) _____

City _____ State _____ Zip _____

Telephone No. () _____ Fax No. () _____

Email _____

3 Section Three Product Selection

Include MVP quotes for products selected

- HMO PPO
 HDHP EPO EPO
 DENTAL INDEMNITY
 POS MEDICARE ADVANTAGE (INFORMATIONAL ONLY)
 HDHP PPO TRIVANTAGE

Desired Effective Date _____

4 Section Four Group Administration

- A. Total number of employees (full-time and part-time) _____
 B. Total number of full-time employees (working a minimum of 20 hours/week) _____
 C. Number of retirees eligible for coverage (Employer must contribute 50% or more of cost)
 1) Non-Medicare Retiree _____
 2) Medicare Retirees _____
 D. Number of net eligible participants (B + C) _____
 E. Number of COBRA/State Continuation Participants _____
 F. Number of eligible employees/retirees waiving coverage _____
 G. Total number of participants eligible to enroll (D + E - F) _____

5 Section Five Other Group Coverage in Addition to MVP

Name of Insurer _____

Address _____

Type of Coverage and Plan Design _____

Effective Date of Policy _____

Name of Insurer _____

Address _____

Type of Coverage and Plan Design _____

Effective Date of Policy _____

Was your Group terminated for non-payment of premium within the last 12 months? Yes No

6 Section Six Enrollment Class/Subgroup

Class Description (ex: All employees working more than 20 hrs/week) _____

Employer Contribution Single _____
 Double _____
 Parent + _____
 Family _____
 Retiree _____
 Non-Medicare _____
 Medicare _____

New Hire Eligibility Policy: Date of Hire
 First of the month following date of hire
 First of the month following _____ days of employment

Indicate number of enrollees by type: Single _____
 Double _____
 Parent + _____
 Family _____
 Medicare _____

6A Section Six (A) Enrollment Class/Subgroup

Class Description (ex: All employees working more than 20 hrs/week) _____

Employer Contribution Single _____
 Double _____
 Parent + _____
 Family _____
 Retiree _____
 Non-Medicare _____
 Medicare _____

New Hire Eligibility Policy: Date of Hire
 First of the month following date of hire
 First of the month following _____ days of employment

Indicate number of enrollees by type: Single _____
 Double _____
 Parent + _____
 Family _____
 Medicare _____

7 Section Seven Certification

To the best of my knowledge, all the statements/responses in this application are true and complete.

By signing this application, I certify that under penalty of perjury that all statements contained in this application are true and accurate to the best of my knowledge. I further certify that I am an officer or employee of this business and that I am duly authorized to execute this application on behalf of the business.

Insurance Fraud Statement

I understand that any person who knowingly and with the 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 (\$5,000) and the stated value of the claim for each such violation.

Print Name _____

Signature _____

Title _____

Date _____

8 Section Eight Broker Information

Broker Name _____

Email _____

Firm Name _____

Address _____

City _____ State _____ Zip _____

Telephone No. () Fax No. ()

9 Section Nine MVP Representative Section

The information provided in this application is true to the best of my knowledge.

Was a Broker involved in this sale? Yes Facets ID _____

No

Print Name _____

Signature _____

Date _____

