MVP HEALTH CARE

INDIVIDUAL ENROLLMENT/CHANGE FORM

ACTION REQUESTED:
☐ **Enroll**
☐ **Change**
☐ **Cancel**

NEW YORK
625 State St. PO Box 2207
Schenectady, NY 12301-2207
518-370-4793 or 1-800-777-4793

1. INFORMATION ABOUT YOURSELF

INSTRUCTIONS TO APPLICANT: Please print or type and complete Sections 1 through 7.

Name *(First, MI, Last)* Marital Status ☐ Single ☐ Married

Address City State Zip County

Phone Email Address

Coverage level ☐ Subscriber ☐ Subscriber & Spouse ☐ Subscriber & Dependents ☐ Family

Eligible for Medicare? ☐ Yes ☐ No Member ID# Spouse/Dependent ID#

Member ☐ A Effective Date ☐ B Effective Date Spouse ☐ A Effective Date ☐ B Effective Date

2. ENROLLMENT/CHANGE

Group #_____ Sub-Group #_____

A. ☐ New Applicant ☐ Add Dependent **REASON:** ☐ Qualifying Event *(describe)*_____
☐ Name Change ☐ Plan Transfer _____
☐ Address Change ☐ Other_____

Requested Effective Date_____

B. ☐ Termination ☐ Remove Dependent(s) only *(please specify)*_____
REASON: ☐ Moved From Area ☐ Opting for Other Coverage
☐ Other_____

Requested Effective Date_____

3. CHOOSE COVERAGE

☐ Standard ☐ Non-Standard ☐ Metal Level _____Metal # (if applicable)_____

A. Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York State of Health-certified stand-alone dental plan offered outside the New York State of Health? ☐ Yes ☐ No

B. If you answered "yes", please provide the name of the company issuing the stand-alone dental coverage. _____ If you answered "no", we will provide you coverage of the pediatric dental essential health benefit. ☐ MVP Dental for Kids ☐ MVP Dental PPO ☐ Delta Dental PPO

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

You and each of your dependents must designate your choice of Primary Care Physician. For help, visit MVP's website **www.mvphealthcare.com** or contact the MVP Customer Care Center. For additional dependents, please list on a separate form.

1. Self

☐ Male ☐ Female Age_____ Date of Birth ____ ____ / ____ ____ /____ ____ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Primary Care Physician (PCP) *(First, Last)* Already a patient? ☐ Yes ☐ No PCP Number
Do you already have pediatric dental essential health benefit coverage? ☐ Yes ☐ No If yes, with whom? If no, we will provide this to you.

2. Name *(First, MI, Last)* Relationship to Subscriber

☐ Male ☐ Female Age_____ Date of Birth ____ ____ / ____ ____ /____ ____ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Primary Care Physician (PCP) *(First, Last)* Already a patient? ☐ Yes ☐ No PCP Number
Do you already have pediatric dental essential health benefit coverage? ☐ Yes ☐ No If yes, with whom? If no, we will provide this to you.

3. Name *(First, MI, Last)* Relationship to Subscriber

☐ Male ☐ Female Age_____ Date of Birth ____ ____ / ____ ____ /____ ____ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Primary Care Physician (PCP) *(First, Last)* Already a patient? ☐ Yes ☐ No PCP Number
Do you already have pediatric dental essential health benefit coverage? ☐ Yes ☐ No If yes, with whom? If no, we will provide this to you.

4. Name *(First, MI, Last)* Relationship to Subscriber

☐ Male ☐ Female Age_____ Date of Birth ____ ____ / ____ ____ /____ ____ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Primary Care Physician (PCP) *(First, Last)* Already a patient? ☐ Yes ☐ No PCP Number
Do you already have pediatric dental essential health benefit coverage? ☐ Yes ☐ No If yes, with whom? If no, we will provide this to you.

5. SIGNATURE

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

_____ **DATE** _____

6. AUTHORIZATION

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 five thousand dollars and the stated value of the claim for each such violation. 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.

7. BROKER

If a broker assisted you with completing this application, please include:

Broker's Name	MVP Agency #	Agency Name
Agency Address	Phone	Email