



SCHENECTADY OFFICE

Enrollment/Change Form

MVP Health Plan, Inc.
MVP Health Insurance Company
MVP Health Services Corp.

ACTION REQUESTED:

- Enroll**
- Change**
- Cancel**

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

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 _____

Phone _____ Employer _____ Date Employed _____ Active Retiree

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 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 1-800-318-8575 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 _____
 Dependent to 30 _____
Effective Date of Change _____

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

3 CHOOSE COVERAGE

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

1. Name (First, MI, Last) _____ Relationship to Employee self
 Male Female Date of Birth ____/____/____ Social Security No. (required) ____-____-____
 Primary Care Physician (PCP) (First, Last) _____ PCP Number _____

2. Name (First, MI, Last) _____ Relationship to Employee spouse/civil union partner Domestic Partner
 Male Female Date of Birth ____/____/____ Social Security No. (required) ____-____-____
 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. (required) ____-____-____ If applicable: College Name _____
 Primary Care Physician (PCP) (First, Last) _____ PCP Number _____ Expected Graduation Date _____
 Eligible for insurance through own employer? Yes No Employer _____

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. (required) ____-____-____ If applicable: College Name _____
 Primary Care Physician (PCP) (First, Last) _____ PCP Number _____ Expected Graduation Date _____
 Eligible for insurance through own employer? Yes No Employer _____

For additional dependents, please list on a separate form.

5 SIGNATURE

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

Late entrant? Yes No

SIGNATURE _____

DATE _____

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, in New York, shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

On behalf of myself and any listed dependents, I (we) hereby apply for membership in MVP. I understand that benefits provided under MVP's Healthy NY plan may be subject to preexisting condition limitations. If applicable, a medical questionnaire will be forwarded to you for your completion. A pre-existing condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month (6) period ending on the enrollment date. We will exclude coverage for health care services during the first twelve (12) months of this Contract that relate to pre-existing conditions.

We will credit to the Covered Person the time he was covered under previous health insurance plans, if the previous coverage was continuous to a date not more than sixty-three (63) days prior to the Enrollment Date of this Contract.

Additionally no pre-existing condition exclusion will be imposed on an "eligible individual" as defined in section 2741(b) of the federal Public Health Service Act, 42 USC §300gg-41(b); nor on those under 19 years of age.

I authorize my employer to deduct from my earnings the necessary contribution, if any, required of me.

I hereby authorize any licensed physician, hospital or other health care provider to furnish MVP with such medical information about myself and my minor eligible dependents listed on the application that may be required to allow MVP to administer my benefits. This authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC.

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