# Health Plan Enrollment or Change
for New York State Individual Plans

**Action Requested:** ☐ **Enrollment** ☐ **Change** ☐ **Termination**

*Please complete all pages of this form.*

Group No.

## Section 1: Information About Yourself *(please include Applicant Name on page 2)*

Applicant Name *(First, Middle Initial, Last)*

Marital Status ☐ Single ☐ Married

Street Address | City | State | Zip Code

County | Home Phone No. ( ) | Mobile Phone No. ( )

Email

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

Are you and/or your spouse eligible for Medicare? ☐ Yes ☐ No

If ***Yes***, provide your Medicare Member ID No(s).
(Yourself) (Spouse, if eligible)

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

***Requested Effective Date***

Reason *(explain)*

☐ Qualifying Event *(explain)*

☐ Other

### Termination

☐ Terminate from Plan
☐ Remove Dependent(s) only *(specify name or member ID no.)*

***Requested Effective Date***

Reason for Termination

☐ Moved from Service Area ☐ Opting for Other Coverage
☐ Other

## Section 3: Choose Your Coverage (Enrollments and Changes)

**Select One:** ☐ Standard Plan Name
☐ Non-Standard Plan Name

**Optional Rider Selection**

☐ Dependent through Age 29 ☐ Unlimited Skilled Nursing

## Section 4: Pediatric Dental Coverage

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 for every person age 18 and under listed in Section 4 of this application, 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
☐ Delta Pediatric Dental PPO



*Continued on page 2*

*Applicant Name*

## Section 5: Information About All Family Members You Want to Enroll in Your Plan (Enrollments and Changes)

You (Subscriber/Applicant) and each individual listed below must designate a choice of Primary Care Physician (PCP). To search for doctors in our network, visit **mvphealthcare.com** and select *Find a Doctor*, or contact the MVP Small Business & Individual Service Unit at **1-844-865-0250** for assistance.
*Please use a separate form for additional individuals.*

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

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

**2** Name *(First, Middle Initial, Last)* | Relationship to Subscriber/Applicant ☐ Spouse ☐ Dependent

☐ Male ☐ Female | Age | Date of Birth *(required)* | Social Security No. *(required)*

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

**3** Name *(First, Middle Initial, Last)* | Relationship to Subscriber/Applicant ☐ Dependent

☐ Male ☐ Female | Age | Date of Birth *(required)* | Social Security No. *(required)*

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

**4** Name *(First, Middle Initial, Last)* | Relationship to Subscriber/Applicant ☐ Dependent

☐ Male ☐ Female | Age | Date of Birth *(required)* | Social Security No. *(required)*

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

**5** Name *(First, Middle Initial, Last)* | Relationship to Subscriber/Applicant ☐ Dependent

☐ Male ☐ Female | Age | Date of Birth *(required)* | Social Security No. *(required)*

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

## Section 6: Authorization *(Your signature is required for Enrollments, Changes, or Terminations)*

I 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.

*Continued on page 3*

*Applicant Name*

*(**Section 6: Authorization** continued from page 2)*

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** (825-5687).

**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 state value of the claim for each violation.**

I have read and agree to this authorization.

Signature Date

## Section 7: Broker Information *(Complete if a broker assisted with completing this application)*

| Broker Name | Broker Email | Phone Number ( ) |
|---|---|---|
| Agency Name | Agency Address | MVP Agency No. |

## Section 8: Private Exchange Information

If you are enrolling via a private exchange (not through NY State of Health™ Marketplace), please provide the name of the private exchange.

**Questions? We're here to help.** Call **1-844-865-0250** Or visit **mvphealthcare.com** Fax: [**1-844-865-0243**]

Return this completed application by mail to **MVP HEALTH CARE 625 STATE ST SCHENECTADY NY 12305-2111**
***(Be sure to include all pages of the form)***