

Health Plan Enrollment or Change

for New York State Large Group Plans



Action Requested: Enrollment Change Termination

Please complete both sides of this form.

To be Completed by Employer (please include Group Name, Group No., and Applicant Name on pages 2 and 3)

Group Name Elmira City School District		Group No. 490253	Subgroup No.	Effective Date
Product ID No.	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 <input type="checkbox"/> Single <input type="checkbox"/> Married	
Street Address		City	State	Zip Code
County	Phone ()	Email		
Do you or any family members have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, with whom? (Name of Carrier)		
Spouse's Health Insurance Carrier (if different than yours)		Spouse's Health Insurance ID No. (if carrier is different than yours)		

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

<p>Enrollment or Change (check all that apply)</p> <input type="checkbox"/> New Applicant <input type="checkbox"/> Add Dependent <input type="checkbox"/> Name Change <input type="checkbox"/> Transfer to Another Plan <input type="checkbox"/> Address Change <input type="checkbox"/> COBRA <p>Requested Effective Date _____</p> <p>Reason</p> <input type="checkbox"/> New Hire (Date of Hire: _____) <input type="checkbox"/> Open Enrollment <input type="checkbox"/> COBRA/State Continuation <input type="checkbox"/> Qualifying Event (explain) _____ _____ <input type="checkbox"/> Other	<p>Termination</p> <input type="checkbox"/> Terminate from Plan <input type="checkbox"/> Remove Dependent(s) only (specify name or member ID no.) _____ _____ <p>Requested Effective Date _____</p> <p>Reason for Termination</p> <input type="checkbox"/> Termination of Employment <input type="checkbox"/> Opting for Other Coverage <input type="checkbox"/> Moved from Service Area <input type="checkbox"/> Other
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Section 3: Choose Your Coverage (Enrollments and Changes)

HMO PPO POS EPO HDHP EPO HDHP PPO Dental

HMO Health Maintenance Organization plan PPO Preferred Provider Organization plan POS Point of Service plan EPO Exclusive Provider Organization plan
 HDHP EPO High Deductible Health Plan Exclusive Provider Organization HDHP PPO High Deductible Health Plan Preferred Provider Organization

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

Continued on page 2

Group Name	Group No.	Applicant Name
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Section 4: Information About All Family Members You Want to Enroll in Your Plan (Enrollments and Changes)

Please use a separate form for additional individuals.

1 Applicant	<input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date of Birth	Social Security No. <i>(required)</i>
Primary Care Physician* <i>(First, Last)</i>			Are you already a patient of this physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP No.

2 Name <i>(First, Middle Initial, Last)</i>				Relationship to Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent
<input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date of Birth	Social Security No. <i>(required)</i>	
Primary Care Physician* <i>(First, Last)</i>			Already a patient of this physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP No.

3 Name <i>(First, Middle Initial, Last)</i>				Relationship to Applicant <input type="checkbox"/> Dependent
<input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date of Birth	Social Security No. <i>(required)</i>	
Primary Care Physician* <i>(First, Last)</i>			Already a patient of this physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP No.

4 Name <i>(First, Middle Initial, Last)</i>				Relationship to Applicant <input type="checkbox"/> Dependent
<input type="checkbox"/> Male <input type="checkbox"/> Female	Age	Date of Birth	Social Security No. <i>(required)</i>	
Primary Care Physician* <i>(First, Last)</i>			Already a patient of this physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	PCP No.

*** For HMO and POS plan applicants,** you (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 Customer Care Center at **1-888-687-6277** for assistance.

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.

By including an email address on this Enrollment/Change form, I agree to accept electronic communication unless otherwise required by law.

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 such violation.

Group Name

Group No.

Applicant Name

(Section 5: Authorization continued from page 2)

I have read and agree to this authorization.

Signature

Date

Questions? We're here to help.



Call **1-800-TALK-MVP** (825-5687)



Or visit **mvphealthcare.com**

MVP HEALTH CARE 625 STATE ST PO BOX 2207 SCHENECTADY NY 12301-2207

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