



INDIVIDUAL ENROLLMENT/CHANGE FORM

ACTION REQUESTED: NEW YORK

- Enroll
- Change
- Cancel

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 _____

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

Requested Effective Date _____ 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)

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)

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)

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