

Enrollment/Change Form

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

HEADQUARTERS
625 State Street, P.O. Box 2207, Schenectady, NY 12301-2207
518/370-4793 1-800/777-4793

LOCAL MARKETING OFFICE:

To reach your local office, call 1-800-TALK-MVP and you will be directed to the appropriate marketing office.

INSTRUCTIONS TO EMPLOYEE: Please print or type and complete Sections 1 through 5

1 PLEASE PROVIDE US WITH INFORMATION ABOUT YOURSELF

Employee Name (Last, First, Initial, Suffix) _____ Sex M F
 Address _____ City _____ State _____ Zip _____ County _____
 Home Phone _____ Business Phone _____ Email Address _____
 Employer _____
 Employer Address _____ City _____ State _____ Zip _____
 Date Employed _____ Full Time Part Time Retired
 Marital Status Single Married Widowed Separated
 Is your spouse employed? Yes No If yes, by whom? _____
 Spouse's health insurance carrier (if other than yours) _____
 Spouse has Individual Coverage Family Coverage Spouse's health insurance ID# _____
 Eligible for Employee ID# _____ Spouse ID# _____
 Medicare? Employee A Effective Date _____ B Effective Date _____
 A Effective Date _____ B Effective Date _____

2 PLEASE INDICATE ENROLLMENT/CHANGE

For address or Primary Care Physician changes, call 1-888-687-6277

A New Applicant
 Name Change
 COBRA/State Continuation
 Add Dependent
Reason:
 New Hire
 Open Enrollment
 COBRA/State Continuation Qualifying Event (please describe) _____

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

3 PLEASE CHOOSE YOUR COVERAGE

HMO* PPO Indemnity Dental
 POS* EPO Healthy NY* Prescription Drug Only
 *Please choose a Primary Care Physician for each family member in Section 4.

4 PLEASE PROVIDE IMPORTANT INFORMATION FOR ALL FAMILY MEMBERS

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 in order for MVP to initiate coverage.

Relationship to Employee	Name First, MI, Last	Date of Birth MM/DD/YY	Social Security Number	Check if Student Over 18	Check if Disabled	Primary Care Physician (PCP) Last and First Name	PCP Number	Check Box if Current Patient
Self <input type="checkbox"/> M <input type="checkbox"/> F	_____	____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>
<input type="checkbox"/> Spouse	_____	____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>
_____	_____	____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>
_____	_____	____/____/____	____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>

NOTE: With the exception of your spouse, each dependent must be under 19 years of age, unless a disability waiver is attached or a rider has been purchased to extend coverage (i.e. student). To obtain a waiver, call MVP.

5 PLEASE SIGN (Employee, spouse, and all dependents 18 years of age or older must sign.)

I HAVE READ AND AGREE TO THE AUTHORIZATION ON THE REVERSE SIDE OF THIS FORM.

Employee's Signature x _____ Date _____
 Spouse's Signature x _____ Date _____
 Dependent's Signature x _____ Date _____
 Dependent's Signature x _____ Date _____

Group # _____ Subgroup # _____ Effective Date _____
 Plan # _____
 Approved By _____
 Employee Class Union Non-Union Hourly
 Salary Management Non-Management
 Employee Dept. (if applicable) _____

TO BE COMPLETED BY EMPLOYER

FOR MVP USE ONLY

ID # _____ Processor _____
 WHITE COPY - MVP CANARY COPY - FMPI OYER PINK COPY - FMPI OYER/TEMPORARY ID

