

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



**Action Requested:**  Enrollment  Change  Termination

Please complete all pages of this form.

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

Applicant Name (First, Middle Initial, Last)		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	
Street Address		City	State   Zip Code
County	Home Phone No. ( )	Mobile Phone No. ( )	
Email			
Are you and/or your spouse eligible for Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> 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

<b>Enrollment or Change</b> (check all that apply) <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	<b>Termination</b> <input type="checkbox"/> Terminate from Plan <input type="checkbox"/> Remove Dependent(s) only (specify name or member ID no.) _____
<b>Requested Effective Date</b> _____	<b>Requested Effective Date</b> _____
<b>Reason</b> (explain) <input type="checkbox"/> Qualifying Event (explain) _____ <input type="checkbox"/> Other _____	<b>Reason for Termination</b> <input type="checkbox"/> Moved from Service Area <input type="checkbox"/> Opting for Other Coverage <input type="checkbox"/> Other _____

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

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

**Select One Medical Plan:**  
 Standard Plan Name \_\_\_\_\_  
 Non-Standard Plan Name \_\_\_\_\_

**Optional Medical Rider Selection**  
 Dependent through Age 29  
 Unlimited Skilled Nursing

**Optional Vision Coverage Level**  Applicant  Applicant and Spouse  Applicant and Dependent(s)  Family  
Vision coverage must be equal to or less than medical coverage.

**Optional Vision Plan (select one)**  MVP Vision 1  MVP Vision 2  MVP Vision 3

## 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 listed in Section 5 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 Pediatric Dental PPO

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

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 [mvphhealthcare.com/findadoctor](http://mvphhealthcare.com/findadoctor) or contact the MVP Small Business & Individual Service Unit at **1-844-865-0250** for assistance.

*Please use a separate form for additional individuals.*

<b>1 Applicant</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary	Age	Date of Birth <i>(required)</i>	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.

<b>2 Name</b> <i>(First, Middle Initial, Last)</i>	Relationship to Subscriber/Applicant <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent			
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary	Age	Date of Birth <i>(required)</i>	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.

<b>3 Name</b> <i>(First, Middle Initial, Last)</i>	Relationship to Subscriber/Applicant <input type="checkbox"/> Dependent			
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary	Age	Date of Birth <i>(required)</i>	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.

<b>4 Name</b> <i>(First, Middle Initial, Last)</i>	Relationship to Subscriber/Applicant <input type="checkbox"/> Dependent			
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary	Age	Date of Birth <i>(required)</i>	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.

<b>5 Name</b> <i>(First, Middle Initial, Last)</i>	Relationship to Subscriber/Applicant <input type="checkbox"/> Dependent			
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary	Age	Date of Birth <i>(required)</i>	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.

**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.

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** (1-800-825-5687).

Yes  No

**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 the NY State of Health Marketplace), provide the name of the private exchange.

**Questions? We’re here to help.**  Call **1-844-865-0250**  Visit **mvphealthcare.com** Fax: **518-386-7595**

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)**