Actively Employed Information

Subscriber: Take this form to the MVP Health Care® (MVP) plan subscriber's employer and complete it together. For the most up-to-date information and accuracy of our records, **please return the completed form to MVP within the month of the member turning 65**.

Employer: Complete this form if the subscriber will continue working past age 65, or if the subscriber will continue to work and cover his/her spouse or domestic partner who is turning 65.

By completing this form, you, the employer, are validating that:

- Your company employs **20 or more people**.
- The subscriber who carries the MVP Health Care policy is not retiring and will continue to work for you as an active employee past age 65, or will continue to work when his/her spouse/domestic partner turns 65.
- You will continue to provide the same health benefits under the same conditions to Medicare eligible employees and the Medicare eligible spouses/domestic partners of employees, as you provide to employees and spouses/domestic partners who are not Medicare eligible. You are required to notify MVP upon retirement of the employee.

Section 1: Group and Subscriber Information

Group Name | **Group** No.

Group Representative Signature | Signature Date | **Group** Phone No. ( )

☐ I certify that the employee listed below is actively working for the group named above.

Employee/MVP Subscriber's Name | Date of Birth

Employee/MVP Subscriber's Member ID No.

Section 2: Information About Individual Turning Age 65

Name of Individual Turning Age 65

Who is turning age 65? ☐ Employee/MVP Subscriber ☐ Spouse ☐ Domestic Partner

If this person is electing Medicare at this time, complete Section 3.

Section 3: Medicare Election

Medicare Part A (Hospital) Effective Date | Medicare Part B (Medical) Effective Date

If Not Eligible for Part A, Explain Why | Medicare Health Insurance Claim No.

Please return this completed form by mail to:

ATTN: COORDINATION OF BENEFITS, MVP HEALTH CARE, PO BOX 2207, SCHENECTADY NY 12301-9884