Health Plan Enrollment or Change Request

For New York State Individual Plans

Instructions for Completing this Request

Please complete all sections of this Request form and return all pages to MVP Health Care® by mail to:
MVP HEALTH CARE, 625 STATE ST, SCHENECTADY NY 12305-2111.

If you have questions or need help with this Request form, call **1-844-865-0250** or visit **mvphealthcare.com**.

Reason for Request *(select one)*: ☐ **Enrollment** ☐ **Change** ☐ **Termination**

Section 1: Applicant Information *(Please include Applicant Name on each page of this Request)*

*(*Required Information)*

Applicant Name* *(First, Middle Initial, Last)*

MVP Member ID No. *(if already an MVP Member)*

Marital Status ☐ **Single** ☐ **Married**

Street Address

City

State

Zip Code

Home Phone No. ( )

County

Email

Mobile Phone No. ( )

Section 2: Enrollment/Change/Termination Information

Enrollment(s) or Change(s) *(select all that apply)*

- ☐ **New Enrollment** *(complete all Sections)*
- ☐ **Add Individual(s) to Current Plan** *(complete Sections 2, 4, and 5)*
- ☐ **Name Change** *(new name entered above, complete Sections 2 and 5)*
- ☐ **Address Change** *(new address entered above, complete Sections 2 and 5)*
- ☐ **Transfer to Another Plan** *(complete Sections 2, 3, and 5)*

Requested Effective Date of Enrollment or Change(s)

Reason for Change(s) *(provide explanation)*

- ☐ **Qualifying Event**
- ☐ **Other**

Termination(s)

- ☐ **Terminate from Plan** *(complete Sections 2 and 5)*
- ☐ **Remove Individual(s) from Plan** *(complete Sections 2 and 5)*

Name(s) or MVP Member ID No(s).

Requested Effective Date of Termination

Reason for Termination

- ☐ **Moved Out of Service Area**
- ☐ **Opting for Other Coverage**
- ☐ **Other**

Section 3: Choose Your Coverage (Enrollments and Changes to Current Coverage)

Select a Medical Coverage Level: ☐ **Applicant** ☐ **Applicant and Spouse** ☐ **Applicant and Dependent(s)** ☐ **Family**

Select one Medical Plan type and provide the Plan Name

- ☐ **Standard Plan** Plan Name
- ☐ **Non-Standard Plan** Plan Name

Select *Optional* Medical Rider(s)

- ☐ **Dependent through Age 29 Coverage**
- ☐ **Unlimited Skilled Nursing Coverage**

Select an *Optional* Vision Coverage Level: ☐ **Applicant** ☐ **Applicant and Spouse** ☐ **Applicant and Dependent(s)** ☐ **Family**

You must select a medical plan if you are choosing to add an optional vision plan.

Select an *Optional* Vision Plan *(select one)*: ☐ **MVP Vision 1** ☐ **MVP Vision 2** ☐ **MVP Vision 3**

{Section 3 continued on page 2)

Company Name *MVP Member ID No.*

*(**Section 3** continued)*

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***, 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 plan)*, as required by the Affordable Care Act.

☐ **MVP Dental for Kids®** ☐ **MVP Dental PPO® for Families** ☐ **Delta Pediatric Dental PPO**

Section 4: Information About All Family Members Enrolling in Your Plan (Enrollments and Changes Only) *(*Required Information)*

All individuals listed below must designate a choice of Primary Care Provider (PCP). To search for doctor's in the MVP network, visit **mvphealthcare.com/findadoctor** or contact the MVP Small Business & Individual Service Unit at **1-844-865-0250** for assistance.

Use a separate form for additional individuals.

Applicant Name | ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth* | Social Security No.*

Primary Care Provider Name* | Are you already a patient of this Provider? ☐ **Yes** ☐ **No** | PCP No.

If ***you*** are age 65 or older, are you currently enrolled in Medicare? ☐ **Yes** *(provide the information below)* ☐ **No**

Your (Applicant) **Medicare** Member ID No. | **Your** (Applicant) **Medicare** Part A and Part B Effective Dates **Part A** **Part B**

Spouse Name | ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth* | Social Security No.*

Primary Care Provider Name* | Already a patient of this Provider? ☐ **Yes** ☐ **No** | PCP No.

If ***your spouse*** is age 65 or older, are they currently enrolled in Medicare? ☐ **Yes** *(provide the information below)* ☐ **No**

Spouse's Medicare Member ID No. | **Spouse's Medicare** Part A and Part B Effective Dates **Part A** **Part B**

Dependent Name | ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth* | Social Security No.*

Primary Care Provider Name* | Already a patient of this Provider? ☐ **Yes** ☐ **No** | PCP No.

Dependent Name | ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth* | Social Security No.*

Primary Care Provider Name* | Already a patient of this Provider? ☐ **Yes** ☐ **No** | PCP No.

Dependent Name | ☐ Male ☐ Female ☐ Non-Binary | Age | Date of Birth* | Social Security No.*

Primary Care Provider Name* | Already a patient of this Provider? ☐ **Yes** ☐ **No** | PCP No.

Company Name *MVP Member ID No.*

Section 5: Authorization

Your signature is required for all enrollments, changes, and terminations.

I hereby apply for membership in MVP Health Care ("MVP") and 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 number listed on the back of my MVP Member ID card.

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 to my MVP online member account at **my.mvphealthcare.com** and selecting *Communication Preferences*.

☐ By checking this box, I attest that I have read and agree to the details outlined in the MVP *Electronic Communications Disclosure*, which is available at **mvphealthcare.com/privacy-notices** or by calling MVP at **1-800-TALK-MVP** (1-800-825-5687).

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 violation.

I have read and agree to this authorization, and I certify that the statements made are true and complete to the best of my knowledge and belief.

Applicant Signature *Signature Date*

Section 6: Broker Information

Complete this Section if a broker assisted with completing this Enrollment or Change Request.

Broker Name	**Broker** Email	Phone No. ( )

Agency Name	Agency Address	MVP Agency No.

Section 7: 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.