



Actively Employed Information Form (Formerly the TEFRA/DEFRA Election Form)

Complete this form if the employer that you will continue to have health care coverage from has 20 or more employees. If the employer has less than 20 employees, **STOP!** Medicare is the primary payer. **Do NOT complete this form.**

Complete this section if **you** are an MVP Health Care plan member who is 65 or over and will remain actively employed.

Your Name:	MVP Health Care Plan Member Number:
Address:	
City, State, ZIP:	
Your Employer:	

I certify that I will continue to work at my current place of employment and will continue their active employee health coverage. I will notify MVP Health Care three months before I leave employment with this employer.

Signature: _____ Date: _____

Complete this section if **your spouse** is actively employed with health care that covers you.

Your Name:	Your Member Number:
Spouse's Name:	Spouse's Date of Birth:
Address:	
City, State, ZIP:	
Spouse's Employer:	Spouse's Member Number:

I certify that I will continue to be covered by the active employee health care coverage of my spouse. I will notify MVP Health Care three months before my spouse leaves employment.

Signature: _____ Date: _____

Inquiries: **Member Services**
(585) 327-2480 or (800) 665-7924 or TTY: (585) 325-2629 or (800) 252-2452
Monday – Friday, 7:00 a.m. – 8:00 p.m. Eastern Time
Nov. 15 – Mar. 1, representatives also are available weekends, 8 a.m. – 8 p.m.