



Today's Date: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_

Disabled Dependent Name: (*confirm*) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Dear Subscriber:

MVP has been notified of your request to cover your disabled dependent under your contract.

In order for this dependent to continue coverage, please complete the following information below marked, "TO BE COMPLETED BY THE SUBSCRIBER". The member's Primary Care Physician should complete a separate form titled "TO BE COMPLETED BY THE PRIMARY CARE PHYSICIAN" - Disability Eligibility Determination Form (also available on MVP's web site). If this information is not received within 30 days, your dependent may be disenrolled from your policy.

Should you have any questions, please feel free to contact our Member Services Department toll-free at 1-888-MVP-MBRS (1-888-687-6277), 8:00 am through 10:00 pm, seven days a week, or via MVP's web site, [www.mvphealthcare.com](http://www.mvphealthcare.com).

**TO BE COMPLETED BY THE SUBSCRIBER**

1. Does your dependent receive social security income for this disability? \_\_\_Yes \_\_\_No
  2. Does your dependent have other insurance coverage, such as Medicare or Medicaid, for this disability? \_\_\_Yes \_\_\_No
  3. Is/was your dependent employed? \_\_\_Yes \_\_\_No – If yes, number of hours per week? \_\_\_\_
  4. Name of Primary Care Physician: \_\_\_\_\_
- Address of Primary Care Physician: \_\_\_\_\_
- Phone number of Primary Care Physician: Area code (\_\_\_\_\_) phone \_\_\_\_\_

Sincerely,

MVP Member Services