



# New Hampshire Enrollment/Change Form

MVP Health Plan of New Hampshire, Inc. / MVP Health Insurance Company of New Hampshire, Inc.

**HEADQUARTERS** 625 State Street, P.O. Box 2207, Schenectady, NY 12301-2207, 518-370-4793, 1-800-777-4793

**LOCAL MARKETING OFFICE:** 33 So. Commercial St., Suite 303, Manchester, NH 03101 | **PH** (603) 647-7181 | **FAX** (603) 647-9607

<b>TO BE COMPLETED BY EMPLOYER</b>	Group # _____	Subgroup # _____	Effective Date _____	Product # _____	Product # _____
Employee Class _____	Employee Dept. (if applicable) _____		Approved by _____		

## 1 INFORMATION ABOUT YOURSELF

**INSTRUCTIONS TO EMPLOYEE:** Please print or type and complete Sections 1 through 5 and 8.

Employee Name (Last, First, Initial, Suffix) \_\_\_\_\_ Marital Status  Single  Married  Civil Union

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Home Phone \_\_\_\_\_ Business Phone \_\_\_\_\_ Email Address \_\_\_\_\_

Employer \_\_\_\_\_ Date Employed \_\_\_\_\_  Full Time  Part Time  Retired

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is your Spouse, Domestic or Civil Union Partner employed?  Yes  No If yes, by whom? \_\_\_\_\_ Spouse, Domestic or Civil Union Partner's health insurance carrier (if other than yours) \_\_\_\_\_

Coverage level  Individual  Family Spouse, Domestic or Civil Union Partner's health insurance ID# \_\_\_\_\_ Effective Date \_\_\_\_\_

Eligible for Medicare?  Yes  No Employee ID# \_\_\_\_\_ Spouse, Domestic or Civil Union Partner ID# \_\_\_\_\_

Employee  A Effective Date  B Effective Date  D Effective Date Spouse, Domestic or Civil Union Partner  A Effective Date  B Effective Date  D Effective Date

## 2 ENROLLMENT/CHANGE

For address or Primary Care Physician changes, call 1-888-687-6277 or visit [www.mvphealthcare.com](http://www.mvphealthcare.com).

- A**  New Applicant **Reason:**
- Name Change  New Hire
  - COBRA  Open Enrollment
  - Add Dependent  COBRA/State Continuation
  - Plan Transfer  Qualifying Event (describe) \_\_\_\_\_
  - Address Change  Other \_\_\_\_\_

- B**  Termination **Reason:**
- Remove Dependent(s) only (please specify) \_\_\_\_\_
  - Termination of Employment  Opting for Other Coverage
  - Moved From Area  Other \_\_\_\_\_

## 3 CHOOSE COVERAGE

- HMO\*  EPO  TriVantage (choose an option):
  - POS\*  Indemnity  Active Lifestyles
  - PPO  HDHP/HSA  Family Focus
  - HealthFirst\*  HDHP  Healthy Alternatives
- \*Please choose a Primary Care Physician—for each family member—in Section 4.

## 4 INFORMATION ABOUT ALL FAMILY MEMBERS YOU WANT ENROLLED UNDER YOUR PLAN

If you are applying for HMO, POS or HealthFirst coverage, you and each of your dependents must designate your choice of Primary Care Physician. For help, visit MVP's Web site [www.mvphealthcare.com](http://www.mvphealthcare.com) or contact MVP Member Services Dept. at 1-888-MVP-MBRS (1-888-687-6277).

**1.** Name (First, MI, Last) \_\_\_\_\_ Relationship to Employee Self

Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security No. (required) \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Primary Care Physician (PCP) (First, Last) \_\_\_\_\_ PCP Number \_\_\_\_\_

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**2.** Name (First, MI, Last) \_\_\_\_\_ Relationship to Employee  Spouse, Domestic or Civil Union Partner

Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security No. (required) \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Primary Care Physician (PCP) (First, Last) \_\_\_\_\_ PCP Number \_\_\_\_\_

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**3.** Name (First, MI, Last) \_\_\_\_\_ Relationship to Employee \_\_\_\_\_ Check all that apply:  Disabled  Current Patient  Full-time Student over 18

Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security No. (required) \_\_\_\_ - \_\_\_\_ - \_\_\_\_ If applicable: College Name \_\_\_\_\_

Primary Care Physician (PCP) (First, Last) \_\_\_\_\_ PCP Number \_\_\_\_\_ Expected Graduation Date \_\_\_\_\_

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**4.** Name (First, MI, Last) \_\_\_\_\_ Relationship to Employee \_\_\_\_\_ Check all that apply:  Disabled  Current Patient  Full-time Student over 18

Male  Female Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security No. (required) \_\_\_\_ - \_\_\_\_ - \_\_\_\_ If applicable: College Name \_\_\_\_\_

Primary Care Physician (PCP) (First, Last) \_\_\_\_\_ PCP Number \_\_\_\_\_ Expected Graduation Date \_\_\_\_\_

**NOTE:** With the exception of your spouse, domestic or civil union partner, each dependent must be (1) a subscriber's child by blood or by law, who is unmarried and one of the following: (i) Under age 19; (ii) Under age 25 if the child is a full-time enrolled student at an educational institution; or (iii) Under age 26, a resident of New Hampshire, and is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other group or individual health benefits plan, group health plan, church plan, or health benefits plan, or entitled to benefits under Title XVIII of the Social Security Act, Public Law 89-97, 42 U.S.C. section 1395 et seq.; or (2) an Adult Disabled Dependent who has submitted a completed Disability Waiver Form. You may download this form from MVP's web site, [www.mvphealthcare.com](http://www.mvphealthcare.com) or contact MVP Member Services Department at 1-888-MVP-MBRS (1-888-687-6277) to request the form.

## 5 OTHER COVERAGE INFORMATION

1. Indicate plans in force during the last 9 months. Please provide Certificates of Creditable Coverage.

2. Do you, your spouse, domestic or civil union partner or any named dependent already have existing health coverage with another company?  Yes  No If yes, please complete the questions below.

Policy Holder of other Health Coverage \_\_\_\_\_

Policy Holder's Relationship to your Dependent's \_\_\_\_\_ Policy Holder's Month and Day of Birth \_\_\_\_\_

Is this insurance Family court ordered?  Yes  No  N/A If Yes, please attach a copy of that section of the court order which pertains to health insurance coverage and complete the questions below.

Do you have physical custody of your dependent(s)?  Yes  No OR Is there joint legal custody?  Yes  No

Where does your dependent(s) reside?  Mother  Father

## 6 AUTHORIZATION

On behalf of myself and any listed dependents, I (we) hereby apply for membership in MVP. I understand that benefits provided under MVP's plans may be subject to preexisting condition limitations.

I hereby authorize any licensed physician, hospital or other health care provider to furnish MVP with such medical information about myself and my minor eligible dependents listed on the application that may be required to allow MVP to administer my benefits.

I hereby represent that the statements made are true and complete to the best of my knowledge and belief.

## 8 SIGNATURE

I have read and agree to the authorization and agreements above.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## 7 AGREEMENTS

I, the undersigned, agree that all answers in the application: (a) are true and complete to the best of my knowledge and belief and (b) will be relied on to determine insurability and (c) which are incorrect for misleading, may void the application effective the issue date.

No Agent/Producer can: (a) waive or change any receipt; or (b) agree to issue a Certificate of Coverage. I have: (a) read the Agreements section and (b) read and approved the answers as recorded. I hereby represent that the statements made are true and complete to the best of my knowledge and belief.