



Out-of-Area Waiver

I acknowledge that I reside outside the approved MVP Health Care Service Area.

I understand that as a MVP Health Care member, my eligible enrolled dependents and I must abide by and follow all rules and regulations regarding access to and provision of health care services in the same manner as those persons residing within the service area; and,

I agree that my eligible enrolled dependents and I will seek care only from MVP Health Care participating providers and facilities, except in the case of life-threatening emergencies as defined by MVP Health Care.

This waiver is hereby attached to and becomes a part of the complete contract between the member and all eligible enrolled dependents and MVP Health Care.

I have read and understand the Out-Of-Area Waiver as indicated by my signature below.

Name (Last, First, MI)

Health Plan ID#

Employer

I UNDERSTAND THAT 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 THERTO, COMMITS A FRADULENT INSURANCE ACT. THIS IS A CRIME AND THE PERSON SHALL BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED \$5,000 AND THE STATE VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Subscriber Signature

Date