

Health Plan Enrollment or Change Request For New York State Student Health 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, PO BOX 2207, SCHENECTADY NY 12301-2207.

If you have questions or need help with this Request form, call **1-800-TALK-MVP** (1-800-825-5687) or visit **mvphealthcare.com**.

Reason for Request (select one): Enrollment Change Termination

Section 1: School Information (To be completed by School)

School Name	Group No.	Effective Date	Approved By
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Section 2: Applicant Information (Please include Applicant Name on each page of this Request)

(*Required Information)

Applicant Name* (First, Middle Initial, Last)	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-Binary	Date of Birth	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
MVP Member ID No. (if already an MVP Member)	Student ID No.	Home Phone No.	Mobile Phone No.
Street Address	City	State	Zip Code
County	Email		

Would you (applicant) like to be added to the New York State Donate Life Registry?*

You can alternatively register directly using the registration link (donatelife.ny.gov/register)

Yes Skip This Question

The New York State Donate Life Registry is a database of people who have signed up to donate their organs, eyes, and/or tissues after their death. This database is kept confidential. If you have opted to donate when obtaining/renewing a New York State driver's license or registering to vote in New York State, your name is already in the Registry database.

Section 3: Enrollment/Change/Termination Information

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

- New Enrollment (complete all Sections)
- Name Change (new name entered above, complete Section 4)
- Address Change (new address entered above, complete Section 4)

Requested Effective Date of Enrollment or Change(s)

Reason for Change(s) (provide explanation)

- Qualifying Event
- Other

Termination(s)

- Terminate from Plan (complete Sections 3 and 6)

Requested Effective Date of Termination

Reason for Termination

- Moved Out of Service Area Opting for Other Coverage
- No Longer Enrolled in the School
- Other

Group Name	Group No.	Applicant Name
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Section 4: 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/notice-privacy-practices-compliance 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