Pending New York State Department of Financial Services approval.

Health Plan Enrollment or Change
for New York State Small Group Plans

Action Requested: ☐ **Enrollment** ☐ **Change** ☐ **Cancellation**

Please complete both sides of this form.

To be Completed by Employer *(please include the Group Name and Group No. on page 2)*

Group Name	Group No.	Subgroup No.	Effective Date

Product ID No.	Product ID No.	Employee Class	Employee Dept. *(if applicable)*	Approved By

Section 1: Information About Yourself *(please print)*

Employee Name *(First, Middle Initial, Last)*

Marital Status ☐ Single ☐ Married

Street Address | City | State | Zip Code

County | Phone ( ) | Email

Do you or any family members have health insurance? ☐ Yes ☐ No

If ***Yes***, with whom?

Spouse's Health Insurance Carrier *(if other than yours)*

Spouse's Health Insurance ID No. *(if carrier is different than yours)*

Coverage Level ☐ Subscriber ☐ Subscriber and Spouse ☐ Subscriber and Dependent(s) ☐ Family

Are you and/or your spouse eligible for Medicare? ☐ Yes ☐ No

If ***Yes***, provide your Medicare Member ID No(s).
(Yourself) (Spouse, if eligible)

If ***Yes***, provide Medicare Parts A and B Effective Dates.
(Yourself) Part A Part B (Spouse) Part A Part B

Section 2: Enrollment/Change/Termination Information

Enrollment or Change *(check all that apply)*

☐ New Applicant ☐ Add Dependant ☐ Name Change
☐ Transfer to Another Plan ☐ Address Change ☐ COBRA

Requested Effective Date

Reason

☐ New Hire (Date of Hire:) ☐ Open Enrollment
☐ Qualifying Event *(explain)*

☐ Other

Termination

☐ Terminate from Plan
☐ Remove Dependant(s) only *(specify name or member ID no.)*

Requested Effective Date

Reason for Termination

☐ Termination of Employment ☐ Opting for Other Coverage
☐ Moved from Service Area
☐ Other

Section 3: Choose Your Coverage (Enrollments and Changes)

☐ Standard ☐ Non-Standard ☐ Metal Level _____ Metal No. (if applicable) _____ ☐ Healthy NY

Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a NY State of Health Marketplace-certified, stand-alone dental plan offered outside of the NY State of Health Marketplace for every person age 18 and under listed in Section 4 of this application, as required by the Affordable Care Act? ☐ Yes ☐ No

If ***Yes***, please provide the name of the company issuing the stand-alone dental coverage.

If you ***No***, MVP will provide you coverage of the pediatric dental essential health benefit *(select one)*, as required by the Affordable Care Act.

☐ MVP Dental for Kids ☐ MVP Dental PPO ☐ Delta Dental PPO

If scanning this form for submission, be sure to scan and return both sides.

Continued on page 2

Group Name	*Group No.*	*Employee Name*

Section 4: Information About All Family Members You Want to Enroll in Your Plan (Enrollments and Changes)

Please use a separate form for additional individuals.

1 Subscriber/Applicant ☐ Male ☐ Female | Age | Date of Birth | Social Security No. *(required)*

Primary Care Physician* *(First, Last)* | Are you already a patient of this physician? ☐ Yes ☐ No | PCP No.

If you are age 18 or under, do you have pediatric dental essential health benefit coverage? ☐ Yes ☐ No | If ***Yes***, with whom? | If ***No***, MVP will provide this coverage to you.

2 Name *(First, Middle Initial, Last)* | Relationship to Subscriber/Applicant ☐ Spouse ☐ Dependent

☐ Male ☐ Female | Age | Date of Birth | Social Security No. *(required)*

Primary Care Physician* *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

If this person is age 18 or under, do you have pediatric dental essential health benefit coverage for him/her? ☐ Yes ☐ No | If ***Yes***, with whom? | If ***No***, MVP will provide this coverage to him/her.

3 Name *(First, Middle Initial, Last)* | Relationship to Subscriber/Applicant ☐ Dependent

☐ Male ☐ Female | Age | Date of Birth | Social Security No. *(required)*

Primary Care Physician* *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

If this person is age 18 or under, do you have pediatric dental essential health benefit coverage for him/her? ☐ Yes ☐ No | If ***Yes***, with whom? | If ***No***, MVP will provide this coverage to him/her.

4 Name *(First, Middle Initial, Last)* | Relationship to Subscriber/Applicant ☐ Dependent

☐ Male ☐ Female | Age | Date of Birth | Social Security No. *(required)*

Primary Care Physician* *(First, Last)* | Already a patient of this physician? ☐ Yes ☐ No | PCP No.

If this person is age 18 or under, do you have pediatric dental essential health benefit coverage for him/her? ☐ Yes ☐ No | If ***Yes***, with whom? | If ***No***, MVP will provide this coverage to him/her.

*** For Healthy NY plan applicants**, you (Applicant) and each individual listed below must designate a choice of Primary Care Physician (PCP). To search for doctors in our network, visit **mvphealthcare.com** and select *Find a Doctor*, or contact the MVP Customer Care Center at **1-888-687-6277** for assistance.

Section 5: Authorization *(Your signature is required for Enrollment, Changes, or Terminations)*

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 $5,000 and the stated value of the claim for each such violation.

On behalf of myself and any individuals listed on this Section 4 of this applications, I hereby apply for membership in MVP. I hereby consent to the release of any medical, health and/or payment information (including without limitation, pharmacy and claims information) about me by any licensed physician, hospital, other health care provider, or authorized federal, state, or local agencies to MVP and any health care providers involved in caring for me, as reasonably necessary to allow MVP to administer my benefits or for MVP or my health care providers to carry out treatment, payment, or health care operations functions, to the extent permitted by law. I also agree that the information released for treatment, payment, and health care operations may include HIV, STD, mental health, or alcohol and substance abuse information about me to the extent permitted by law, until I revoke this consent.

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

By including an email address on this Enrollment/Change form, you agree to accept electronic communication unless otherwise required by law.

I have read and agree to this authorization.

Signature Date