ROCHESTER OFFICE

Enrollment/Change Form

ACTION REQUESTED: ☐ Enroll ☐ Change ☐ Cancel

EMPLOYER GROUP MUST COMPLETE	GROUP NAME	COMPLETE DIVISION NUMBER	COVERAGE/CHANGE EFFECTIVE DATE	EMPLOYER VERIFICATION (INITIALS REQUIRED)

1 SUBSCRIBER INFORMATION

Instructions to employee: Please print or type and complete Sections 1 – 5.

Last Name First Name Middle Social Security # (or Health ID #)

Address (Street) City State Zip Phone

Employer Date Employed (if applicable) ☐ Active ☐ Retiree

2 ENROLLMENT/CHANGE

For address or Primary Care Physician changes, call **1-800-950-3224** or visit **www.mvphealthcare.com.**

A

☐ New Applicant
☐ COBRA
ID # ________________
☐ Add Dependent
☐ Change Health Plan Type
☐ Information Change

Reason:
☐ New Hire
☐ Open Enrollment
☐ COBRA/NYSC
☐ Former employee
☐ Former dependent
☐ Qualifying Event ____________
☐ Other ____________________

B

☐ Termination
☐ Remove Dependent(s) only *(fill out Section 4)*

Reason:
☐ Termination of Employment
☐ Loss of Eligibility
☐ Moved From Area
☐ COBRA Coverage Expired
☐ Qualifying Event ________________
☐ Other ________________________

COVERAGE LEVEL REQUESTED

☐ Single ☐ Two Person ☐ Employee+Children ☐ Family

3 CHOOSE COVERAGE

Type of Plan

GROUP HMO OR POS (ACCESS PLUS)

☐ Basix
☐ Community
☐ Comprehensive
☐ Opportunity

☐ TriVantage *(select one)*
☐ Active Lifestyles
☐ Family Focus
☐ Healthy Alternatives

EPO/PPO PLAN

☐ CareFund PPO: HSA __1__2__3 HRA __1__2__3
☐ MyCare PPO __1__2__3
☐ Preferred EPO __1__2__3__4
☐ USDirect PPO

DIRECT BILL

☐ Personal Plan HMO
☐ Personal Plan POS
☐ PPO Conversion
☐ Healthy NY

OTHER

____

____

4 INFORMATION ABOUT ALL FAMILY MEMBERS TO BE ENROLLED OR UPDATED

If you are applying for HMO, POS or Healthy NY coverage, you and each of your dependents must designate your choice of Primary Care Physician (PCP). If covering a child placed for pre-adoption, a disabled dependent, a grandchild, foster child, or adding a domestic partner, please see your employer for eligibility guidelines.

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

☐ Male ☐ Female Date of Birth __ __/__ __/__ __ Social Security No. __ __ __ - __ __ - __ __ __ __

PCP (First, Last) PCP Number

2. Name (First, MI, Last) Relationship to Employee ☐ Spouse ☐ Domestic Partner ☐ **ADD** ☐ **CANCEL**

☐ Male ☐ Female Date of Birth __ __/__ __/__ __ Social Security No. __ __ __ - __ __ - __ __ __ __

PCP (First, Last) PCP Number

3. Name (First, MI, Last) Relationship to Employee ☐ **ADD** ☐ **CANCEL**

☐ Male ☐ Female Date of Birth __ __/__ __/__ __ Social Security No. __ __ __ - __ __ - __ __ __ __ FT Student over 19 (12+ hrs.)? ☐ Yes ☐ No School Name ________________

PCP (First, Last) PCP Number Eligible for insurance through own employer? ☐ Yes ☐ No Employer ____________

4. Name (First, MI, Last) Relationship to Employee ☐ **ADD** ☐ **CANCEL**

☐ Male ☐ Female Date of Birth __ __/__ __/__ __ Social Security No. __ __ __ - __ __ - __ __ __ __ FT Student over 19 (12+ hrs.)? ☐ Yes ☐ No School Name ________________

PCP (First, Last) PCP Number Eligible for insurance through own employer? ☐ Yes ☐ No Employer ____________

For additional dependents, please list on a separate form.

5 SUBSCRIBER SIGNATURE

I have read and agree to the Terms of Participation on the reverse side of this form.

SUBSCRIBER SIGNATURE ____ **DATE** ________________

PC335 (05/09)

TERMS OF PARTICIPATION

Please read the following carefully. Your signature on this form indicates that you agree to all of the following:

I understand that the effective date of coverage is when I may begin using MVP Health Plan services. MVP will send me final confirmation of my enrollment.

By enrolling in MVP Health Plan, Inc., I authorize MVP to use or disclose my personal health information for treatment, payment or healthcare operation purposes, unless otherwise required by law. Those purposes include, but are not limited to, disease prevention and management, coordination of treatment and benefits, utilization and claims review, quality assessment and measurement, grievance and appeals, accreditation, for the duration of this contract.

If I am a member of an MVP HMO plan (covered by MVP Health Plan, Inc.), I understand that it is my responsibility to inform MVP before permanently moving or leaving the service area for more than three (3) consecutive months. I also understand that if I am absent from the service area for more than three (3) consecutive months, MVP may be required to disenroll me.

If I am a member of an MVP EPO or PPO plan, I understand that I am not required to select a Primary Care Physician and that it is my physician's responsibility to obtain any necessary prior authorizations from MVP. I will review my MVP EPO or PPO Plan Certificate to understand my responsibilities.

I understand that I may be applying for a health plan that includes a Pre-existing Condition limitation (example: Direct Bill, Healthy NY, Chamber and Association Groups) and that I will be held to the limitations and conditions set forth in my contract or certificate as they apply to this limitation. A pre-existing condition is a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month (6) period ending on the enrollment date. We will exclude coverage for health care services during the first twelve (12) months of this Contract that relate to pre-existing conditions.

We will credit to the Covered Person the time he was covered under previous health insurance plans, if the previous coverage was continuous to a date not more than sixty-three (63) days prior to the Enrollment Date of this Contract.

Additionally, no pre-existing condition exclusion will be imposed on an "eligible individual" as defined in section 2741(b) of the federal Public Health Service Act, 42 USC §300gg-41(b).

I have been informed that I may disenroll from MVP at any time. To cancel coverage I must write to my employer group or, if enrolled in a Healthy New York, Personal Plan, or Direct Bill Plan, I must write to MVP.

If I am eligible for Medicare Part B, I understand that choosing a commercial health plan without also taking Medicare Part B could have serious financial implications that may include limitations on my coverage. I also understand that if I do not have Medicare prescription drug coverage , or creditable prescription drug coverage (as good as Medicare's) I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. I have read my Medicare and You Booklet and understand the information it contains regarding coordination of benefits and exclusions. I will review the section on Exclusions, Limitations, and Non-Covered Services in my MVP Certificate/Contract to understand the effect this has on my coverage.

PLEASE NOTIFY MVP AND YOUR EMPLOYER IMMEDIATELY WHEN ANY INFORMATION ON THIS FORM CHANGES OR IF YOU ARE COVERED BY ANOTHER HEALTH PLAN.

I understand that this enrollment and subsequent acceptance of service by me, my spouse and/or eligible dependents are subject to the terms of the MVP Certificates and/or Contracts. I authorize my employer to deduct in advance from any accrued or earned wages due me, such amount as may be necessary to pay for my MVP coverage and to remit the same to MVP. I authorize any physician, hospital, or other medical facility or provider to release to MVP any and all records and information regarding services requested or received while any of the persons listed on this form are members of MVP.

If I have applied for an HMO plan, I understand that beginning on my effective date, I must get all my health care from MVP Participating Providers except for Emergency and Urgent Care while I am away from home. I understand that services authorized by MVP will be covered. I also understand that without authorization (except for Emergency Services), MVP WILL NOT PAY FOR THE SERVICES. I understand that I must select a Primary Care Physician (PCP) who must coordinate my care in order to properly administer my benefits under the MVP HMO coverage. I also understand that, if I am applying for MVP POS coverage, which includes TriVantage Healthy Alternatives, I am purchasing an insurance plan in addition to my MVP HMO coverage. If I have applied for an EPO or PPO plan, I understand that I am not required to select a PCP and that it is my physician's responsibility to obtain any necessary prior authorization from MVP. I understand that my signature on this application means that I have read and understand the contents of this application. I also understand that I am applying for an MVP Health Plan as specified on my application that is subject to the rules and guidelines as specified in that certificate or contract. I represent to you that all information furnished by me on this form is true and complete to the best of my knowledge. Any person who knowingly and with intent to defraud any insurance company or other person who 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 a civil penalty not to exceed five thousand dollars ($5,000) and the stated value of the claim for each violation.