



CHAMBER OF COMMERCE/PROFESSIONAL ASSOCIATION/MULTI-EMPLOYER GROUPS Enrollment Application/Change Form

MVP Health Plan, Inc.
MVP Health Insurance Company
MVP Health Services Corp.
Preferred Assurance Company, Inc.

ACTION REQUESTED: Enroll Change Cancel

1 INFORMATION ABOUT YOURSELF

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

Employee Name (Last, First, Initial, Suffix) _____ Marital Status Single Married

Address _____ City _____ State _____ Zip _____ County _____

Phone _____ Date Employed _____ Active Retiree

Do you or any other family members have health insurance? Yes No If yes, by whom? _____ Spouse's health insurance carrier (if other than yours) _____ Coverage Individual Family Spouse's health insurance ID# _____

Eligible for Medicare? Yes No Employee ID# _____ Spouse ID# _____ Part A Effective Date _____ Part B Effective Date _____

Employee Part A Effective Date _____ Spouse Part A Effective Date _____ Part B Effective Date _____

2 ENROLLMENT/CHANGE

For address or Primary Care Physician changes, call 1-800-318-8575 or visit www.mvphealthcare.com.

A Effective Date _____ Reason: New Applicant Name Change COBRA Add Dependent Plan Change to _____ Address Change Dependent to 30 _____

B Effective Date _____ Termination Remove Dependent(s) only (please specify) _____

Reason: Open Enrollment COBRA/State Continuation Qualifying Event (describe) _____ Termination of Employment Opting for Other Coverage Moved From Area Other _____

3 CHOOSE COVERAGE Product ID # _____ HMO* PPO EPO HDHP/HSA HDHP Dental TriVantage Active Lifestyles Family Focus 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

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 _____

2. Name (First, MI, Last) _____ Relationship to Employee spouse/civil union partner Domestic Partner

Male Female Date of Birth ____/____/____ Social Security No. (required) _____

Primary Care Physician (PCP) (First, Last) _____ PCP Number _____

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 _____

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 _____

*Applicable to HMO products only. This information will be used to determine eligibility for student out-of-area coverage. For additional dependents, please list on a separate form.

5 EMPLOYEE SIGNATURE

I have read and agree to the authorization below.

SIGNATURE _____ DATE _____

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, in New York, shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

On behalf of myself and any listed dependents, I (we) hereby apply for membership in MVP. I understand that benefits provided under my plan may be subject to preexisting condition limitations. If applicable, a medical questionnaire will be forwarded to you for your completion. 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 authorize my employer to deduct from my earnings the necessary contribution, if any, required of me.

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. This authorization excludes the release of any information about previously administered tests for HIV antibodies, T-cell counts, AIDS or ARC.

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

6 MUST BE COMPLETED IN FULL BY EMPLOYER

Employer Name _____ Effective Date _____ Sole Proprietor OR Employer Group (Groups of 2 or more)

of Employees (required) _____ Social Security Number or Tax ID Number (required) _____

Employer Address _____ City _____ State _____ Zip _____

When did employee become eligible for coverage (N/A for retirees)? _____ New Employer? (required) Yes No

Is applicant currently working at least 20 hrs/week? Yes No N/A for retiree Subscriber, including sole proprietor, must be employed a minimum of 20 hours per week in order to qualify for benefits under this contract.

Chamber/Association Name _____ Date employer joined Chamber/Association _____

Employer Signature _____ Date of Signature _____

7 ASSOCIATION/CHAMBER SIGNATURE

SIGNATURE _____ DATE _____