



# Enrollment Application

**PLEASE MAKE SURE TO COMPLETE ALL SIX SECTIONS**

**APPLICATION FOR ENROLLMENT**

- new hire
- open enrollment
- loss of coverage

**REQUEST FOR CHANGE**

- change health plan
- add dependent
- remove dependent
- other \_\_\_\_\_

**CANCEL COVERAGE**

- open enrollment
- employment terminated
- moved out of area
- employee deceased
- other \_\_\_\_\_

**COBRA/NYSC**

- former employee
- former dependent

## 1 SUBSCRIBER INFORMATION

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

Telephone Home \_\_\_\_\_ Work \_\_\_\_\_

Social Security Number \_\_\_\_\_ Marital Status \_\_\_\_\_ Sex \_\_\_\_\_

Current Health Insurance \_\_\_\_\_

Have you ever been a member of MVP Health Care?  Yes  No Contract Number \_\_\_\_\_

Have you or any of your dependents been covered by another health plan during the last 63 days (excluding any waiting periods)?  Yes  No

Please note, that a "No" answer means that expenses resulting from any conditions for which care was received or recommended during the last six months (excluding employer waiting period) will not be covered until you have completed a twelve (12) month waiting period. If you had prior coverage which terminated within 63 days of your effective date (excluding employer waiting period), your prior coverage may be eligible to satisfy all or part of your twelve (12) month waiting period. **Please complete the Previous Insurance Information section on the back and attach all qualifying documentation.**

**You must select a PCP in order for MVP Health Care to properly administer coverage under your MVP Health Care health plan unless you are a MVP Health Care PPO member.**

## 2 SUBSCRIBER AND DEPENDENT INFORMATION

|  | SUBSCRIBER  | DEPENDENT   | DEPENDENT   | DEPENDENT   |
|--|---|---|---|---|
| NAME (last if different) FIRST, MI                                 |   |   |   |   |
| BIRTH DATE (MM/DD/YY)  | / /   | / /   | / /   | / /   |
| RELATIONSHIP (SPOUSE, CHILD)                                       | SUBSCRIBER  |   |   |   |
| SOCIAL SECURITY NO.  |   |   |   |   |
| SEX  | <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE                                 | <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE                                 | <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE                                 | <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE                                 |
| PRIMARY CARE PHYSICIAN NAME<br>(Females may also choose an OB/GYN) | (PCP)   | (PCP)   | (PCP)   | (PCP)   |
|  | (OB/GYN)  | (OB/GYN)  | (OB/GYN)  | (OB/GYN)  |
| PHYSICIAN SEQUENCE NUMBER<br>(from Physician's listing)            | (PCP)   | (PCP)   | (PCP)   | (PCP)   |
|  | (OB/GYN)  |   |   |   |
| PRIMARY CARE PHYSICIAN ADDRESS                                     | (PCP)   | (PCP)   | (PCP)   | (PCP)   |
|  | (OB/GYN)  | (OB/GYN)  | (OB/GYN)  | (OB/GYN)  |
| CURRENT PATIENT?   | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Will Accept | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Will Accept | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Will Accept | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> Will Accept |
| FULL TIME STUDENT?   | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A         | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A         | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A         | <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> N/A         |



### 3 PREVIOUS INSURANCE INFORMATION

|                                     | SUBSCRIBER   | DEPENDENT  | DEPENDENT  | DEPENDENT  |
|-------------------------------------|--|--|--|--|
| EFFECTIVE DATE OF PREVIOUS COVERAGE |  |  |  |  |
| TERMINATION DATE                    |  |  |  |  |
| CARRIER'S NAME                      |  |  |  |  |
| IS MEMBER ELIGIBLE FOR MEDICARE?    | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |

### 4 ASSOCIATION/CHAMBER INFORMATION

**ASSOCIATION/CHAMBER NAME**

(PLEASE CHECK PLAN CHOICE):

|  |   |                                       |
|--|---|---------------------------------------|
| <b>Group HMO:</b>                      | <b>TriVantage:</b>                            | <b>PPO Plan:</b>                      |
| <input type="checkbox"/> Opportunity   | <input type="checkbox"/> Active Lifestyles    | <input type="checkbox"/> USdirect     |
| <input type="checkbox"/> Basix         | <input type="checkbox"/> Family Focus         | <input type="checkbox"/> CareFund HSA |
| <input type="checkbox"/> Community     | <input type="checkbox"/> Healthy Alternatives | <input type="checkbox"/> CareFund HRA |
| <input type="checkbox"/> Comprehensive |   | <input type="checkbox"/> Other:       |

DIVISION # \_\_\_\_\_ SOLE PROPRIETOR:  YES  NO

### 5 MUST BE COMPLETED IN FULL BY EMPLOYER AND ASSOCIATION

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Employer Phone Number \_\_\_\_\_ Tax ID Number \_\_\_\_\_

Does employee meet waiting period criteria?  YES  NO

When was employee hired (N/A for retiree)? \_\_\_\_\_ When did employee become eligible for coverage (N/A for retiree)? \_\_\_\_\_

**Effective date of coverage/change:** \_\_\_\_\_

**Employer Signature** \_\_\_\_\_ **Date of Signature** \_\_\_\_\_

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.*

**Association/Chamber Verification**

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

PLEASE BE SURE YOUR APPROPRIATE DOCUMENTATION IS ATTACHED

### 6 AUTHORIZATION AND AGREEMENT

I certify that the information given on this form is correct to the best of my knowledge and I have read and agree to the authorization. I understand that MVP Health Care (MVP) may require verification of my employment with a bonafide employer, or as sole proprietor. I understand that benefits are not payable for expenses resulting from pre-existing conditions during the first twelve (12) months of coverage received, unless all or part of the twelve (12) month waiting period has been satisfied by prior coverage. 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. **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 TriVantage Healthy Alternatives I am purchasing a POS insurance plan, in addition to my MVP HMO coverage, which will require me to work with my physician to obtain any necessary precertification, while I am out of the service area. I understand that if I have applied for a USdirect PPO plan it is my responsibility to work with my physician and MVP to obtain any necessary precertification. 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/contract. I understand that my signature on this application means that I have read and understand the contents of this application. I hereby authorize any physician hospital or other medical facility or provider to release to MVP any and all records and information regarding services requested while any of the persons on this contract are members of MVP, and I also authorize the release of records and information relating to prior treatment and/or services. I represent to you that all information furnished by me on this form is true and complete to the best of my knowledge.

**Subscriber 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 shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.