



Enrollment/Change Form

MVP Health Plan, Inc. / MVP Health Insurance Company / MVP Health Services Corp.
HEADQUARTERS 625 State Street, P.O. Box 2207, Schenectady, NY 12301-2207, 518-370-4793, 1-800-777-4793
LOCAL MARKETING OFFICE: Call 1-800-TALK-MVP and you will be directed to the appropriate marketing office.

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 _____

Home Phone _____ Business Phone _____ Email Address _____

Employer _____ Date Employed _____ Full Time Part Time Retired

Employer Address _____ City _____ State _____ Zip _____

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 level Individual Family Spouse's health insurance ID# _____

Eligible for Medicare? Yes No Employee ID# _____ Spouse ID# _____

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

2 ENROLLMENT/CHANGE

For address or Primary Care Physician changes, call 1-888-687-6277 or visit www.mvphealthcare.com.

A New Applicant Reason: _____ Termination

Name Change New Hire Remove Dependent(s) only (please specify) _____

COBRA Open Enrollment

Add Dependent COBRA/State Continuation

Plan Transfer Qualifying Event (describe) _____

Address Change Other _____

B Termination Reason: _____

Remove Dependent(s) only (please specify) _____

Moved From Area Opting for Other Coverage

Moved From Area Other _____

3 CHOOSE COVERAGE

HMO* Healthy NY* TRVantage (Choose an option):

PPO Prescription Drug Only Active Lifestyles

Indemnity High Deductible EPO Family Focus

Dental High Deductible PPO Healthy Alternatives

POS* EPO

*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

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 in order for MVP to initiate coverage. NOTE: Any dependents over dependent maximum age will require a waiver.

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

Male Female Date of Birth _____ / _____ / _____ Social Security No. _____

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

2. Name (First, MI, Last) _____ Relationship to Employee spouse partner

Male Female Date of Birth _____ / _____ / _____ Social Security No. _____

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

3. Name (First, MI, Last) _____ Relationship to Employee _____

Male Female Date of Birth _____ / _____ / _____ Social Security No. _____

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

4. Name (First, MI, Last) _____ Relationship to Employee _____

Male Female Date of Birth _____ / _____ / _____ Social Security No. _____

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

Check all that apply: Disabled Current Patient Full-time Student over 18

If applicable: College Name _____ Expected Graduation Date _____

Check all that apply: Disabled Current Patient Full-time Student over 18

If applicable: College Name _____ Expected Graduation Date _____

5 SIGNATURE

I have read and agree to the authorization of the reverse side of this form. Late entrant? Yes No

SIGNATURE _____

DATE _____

TO BE COMPLETED BY EMPLOYER

Employee Class _____ Group # _____ Subgroup # _____ Effective Date _____ Product # _____

Employee Dept. (if applicable) _____ Approved by _____ Product # _____