INDIVIDUAL ENROLLMENT/CHANGE FORM

ACTION REQUESTED:
☐ **Enroll**
☐ **Change**
☐ **Cancel**

NEW YORK
625 State St. PO Box 2207
Schenectady, NY 12301-2207
518-370-4793 or 1-800-777-4793

1. INFORMATION ABOUT YOURSELF

INSTRUCTIONS TO APPLICANT: Please print or type and complete Sections 1 through 7.

Name *(First, MI, Last)* Marital Status ☐ Single ☐ Married

Address City State Zip County

Phone Email Address

Coverage level ☐ Subscriber ☐ Subscriber & Spouse ☐ Subscriber & Dependents ☐ Family

Eligible for Medicare? ☐ Yes ☐ No Member ID# Spouse/Dependent ID#

Member ☐ A Effective Date ☐ B Effective Date Spouse ☐ A Effective Date ☐ B Effective Date

2. ENROLLMENT/CHANGE

Group #_____ Sub-Group #_____

A. ☐ New Applicant ☐ Add Dependent **REASON:** ☐ Qualifying Event *(describe)*_____
☐ Name Change ☐ Plan Transfer _____
☐ Address Change ☐ Other_____

Requested Effective Date_____

B. ☐ Termination ☐ Remove Dependent(s) only *(please specify)*_____
REASON: ☐ Moved From Area ☐ Opting for Other Coverage
☐ Other_____

Requested Effective Date_____

3. CHOOSE COVERAGE

☐ Standard ☐ Non-Standard ☐ Metal Level _____Metal # (if applicable)_____

A. Have you obtained stand-alone dental coverage that provides a pediatric dental essential health benefit through a New York State of Health-certified stand-alone dental plan offered outside the New York State of Health? ☐ Yes ☐ No

B. If you answered "yes", please provide the name of the company issuing the stand-alone dental coverage. _____ If you answered "no", we will provide you coverage of the pediatric dental essential health benefit. ☐ MVP Dental for Kids ☐ MVP Dental PPO ☐ Delta Dental PPO

4. INFORMATION ABOUT ALL FAMILY MEMBERS YOU WANT ENROLLED UNDER YOUR PLAN

You and each of your dependents must designate your choice of Primary Care Physician. For help, visit MVP's website **www.mvphealthcare.com** or contact the MVP Customer Care Center. For additional dependents, please list on a separate form.

1. Self

☐ Male ☐ Female Age_____ Date of Birth ____ ____ / ____ ____ / ____ ____ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Primary Care Physician (PCP) *(First, Last)* Already a patient? ☐ Yes ☐ No PCP Number
Do you already have pediatric dental essential health benefit coverage? ☐ Yes ☐ No If yes, with whom? If no, we will provide this to you.

2. Name *(First, MI, Last)* Relationship to Subscriber

☐ Male ☐ Female Age_____ Date of Birth ____ ____ / ____ ____ / ____ ____ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Primary Care Physician (PCP) *(First, Last)* Already a patient? ☐ Yes ☐ No PCP Number
Do you already have pediatric dental essential health benefit coverage? ☐ Yes ☐ No If yes, with whom? If no, we will provide this to you.

3. Name *(First, MI, Last)* Relationship to Subscriber

☐ Male ☐ Female Age_____ Date of Birth ____ ____ / ____ ____ / ____ ____ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Primary Care Physician (PCP) *(First, Last)* Already a patient? ☐ Yes ☐ No PCP Number
Do you already have pediatric dental essential health benefit coverage? ☐ Yes ☐ No If yes, with whom? If no, we will provide this to you.

4. Name *(First, MI, Last)* Relationship to Subscriber

☐ Male ☐ Female Age_____ Date of Birth ____ ____ / ____ ____ / ____ ____ Social Security No. ***(required)*** ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Primary Care Physician (PCP) *(First, Last)* Already a patient? ☐ Yes ☐ No PCP Number
Do you already have pediatric dental essential health benefit coverage? ☐ Yes ☐ No If yes, with whom? If no, we will provide this to you.

5. SIGNATURE

I have read and agree to the authorization of the reverse side of this form.

_____ **DATE** _____ ▶

6. AUTHORIZATION

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 five thousand dollars and the stated value of the claim for each such violation. 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.

7. BROKER

If a broker assisted you with completing this application, please include:

Broker's Name Jay Gerlitz | MVP Agency # 406 | Agency Name Jay Z. Gerlitz & Associates, Inc.

Agency Address 207 Briarwood Drive, Somers, NY 10589 | Phone 914-277-2227 | Email jay@gerlitzgroup.com

ONE TIME DIRECT DEBIT AUTHORIZATION FORM

SECTION 1: MEMBER INFORMATION

_____
Member Name (Please Print)

_____
Street Address

_____
City / State / ZIP

_____
Daytime Phone Number

SECTION 2: ONE TIME DIRECT DEBIT PAYMENT AUTHORIZATION

I hereby authorize MVP Health Care to withdraw the amount due to MVP immediately upon receipt for the provision of health benefits.

_____ _____
Signature Date

In the case of an automatic bank debit form of payment, it shall be the Customer's responsibility to verify whether this payment is properly debited from their bank account. This authorization is for a One Time only debit for the initial premium payment.

PLEASE KEEP A COPY OF THE AUTHORIZATION FOR YOUR RECORDS

Staple a VOIDED check or photocopy of a VOIDED check

Direct Debit authorization must be sent with your completed enrollment form. Please follow enrollment instructions included in this packet.

(11/14)

AFFIDAVIT for QUALIFYING EVENT – SPECIAL OPEN ENROLLMENT PERIOD

STATE OF _____)

) ss.:

COUNTY OF _____)

The undersigned, being duly sworn, deposes and says:

I seek to enroll in coverage in an individual insurance plan through MVP Health Plan, Inc. outside of the annual Open Enrollment period (between November 1st through January 31st). I am completing this Affidavit as the Subscriber (and on behalf of my Spouse or Child, if applicable) within 60 days of the occurrence of one of the following events (check all that apply):

_____ You or Your Spouse or Child loses minimum essential coverage. (Voluntary termination or termination for non-payment does not qualify as a loss of coverage)

_____ You move and become eligible for new health plans.

_____ You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption.

_____ You become pregnant (certification from doctor required for effective date eligibility).

_____ You, Your Spouse or Child exhausted Your COBRA or continuation coverage.

("You" refers to the individual completing this Affidavit)

***This form MUST be Notarized if you are eligible for one of the following Qualifying Events:**

_____ * Your enrollment or non-enrollment in another health plan was unintentional, inadvertent or erroneous and was the result of the error, misrepresentation, or inaction of an officer, employee, or agent of a health plan or the Exchange **(NEEDS TO BE NOTARIZED).**

_____ * You adequately demonstrate to MVP that another health plan in which You were enrolled substantially violated a material provision of its contract **NEEDS TO BE NOTARIZED).**

_____ * You are determined newly eligible or newly ineligible for advance payments of the premium tax credit or have a change in eligibility for cost-sharing reductions **NEEDS TO BE NOTARIZED).**

("You" refers to the individual completing this Affidavit)

Date of Qualifying Event _____ (MVP must receive notice and any premium payment within 60 days of these events)

Through my below signature, I certify that I (and my Spouse and/or Child, if applicable) meet the guidelines to enroll in an individual plan through MVP based on the above qualifying event(s) that I have indicated apply. I declare that I have made this certification to the best of my knowledge and belief. Should I later learn or discover that one, or all, of the qualifying events was not true and correct, I will promptly notify MVP of this new information.

Print Name: _____

Signature: _____

Address: _____ Phone:_____

FOR ITEMS WITH AN ASTERISK (*)

Sworn to before me this_____day of_____, 20_____

_____

Notary Public

6/15