Medicare Advantage Health Plans

Employer Group Enrollment with Part D Application

By completing this Enrollment Application, I agree to the following:

MVP Health Plan, Inc. is a Medicare Advantage plan and has a contract with the Federal government. I will need to keep my Medicare Parts A and B. **I can be in only one Medicare Advantage plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare Advantage health plan.**

It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't 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.

Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15–December 7 of every year), or through my employer group.

MVP Health Plan, Inc. serves a specific service area. If I move out of the area that MVP serves, I need to notify the plan so I can disenroll and find a new plan in my new area.

Once I am a member of MVP, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage (contract) from MVP when I get it to know which rules I must follow to get coverage with this Medicare Advantage plan.

I understand that people with Medicare aren't usually covered under Medicare while out of the country except for limited coverage near the U.S. border. MVP's Medicare Advantage plans offer worldwide coverage for emergency care.

I understand that beginning on the date MVP coverage begins, I must get all of my health care from MVP, except for emergency or urgently needed services, or out-of-area dialysis services. Services authorized by MVP and other services contained in my MVP Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, neither Medicare nor MVP will pay for these services.

I understand that if I am getting assistance from a sales agent, broker, or other individual employed by or contracted with MVP, he/she may be paid based on my enrollment in MVP.

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Please complete Steps 1–6. Complete one enrollment application per applicant.

Step 1: Plan Enrollment Selection for Employer Group or Union Member *(Please print)*

Employer or Union Name	Group No.	Date Coverage to Begin

Please select which employer group plan you are enrolling in:

☐ **MVP Preferred Gold HMO-POS with Part D** prescription drug coverage	Product ID No.	Subgroup No.
☐ **MVP® USA Care PPO® with Part D** prescription drug coverage	Product ID No.	Subgroup No.

Step 2: Provide Information About Yourself *(Please print)*

Name *(last, first, middle initial)*	Gender ☐ Male ☐ Female	Date of Birth

Permanent Residence Street Address *(PO Box is not allowed)*	Preferred Phone No. ( )

City	State	Zip Code	County

Mailing Address *(if different from Permanent Address)*	City	State	Zip Code

Email Address *(optional)*

Step 3: Provide Your Medicare Insurance Information

Using your Medicare card, fill in these blanks so they match your red, white, and blue Medicare card.
Or attach a copy of your Medicare card, or your letter from Social Security or the Railroad Retirement Board.
You must have Medicare Part A and Part B to join a Medicare Advantage plan.

Name (as it appears on your Medicare card)	Medicare Number

Is Entitled To:

Hospital (Part A) Effective Date	Medical (Part B) Effective Date

Step 4: Provide the Name of Your Primary Care Physician (PCP)

Complete this Step only if you are enrolling in Preferred Gold HMO-POS plan.

PCP's Full Name

Are you an existing patient?
☐ **Yes** ☐ **No**

Step 5: Read and Provide Answers to the Following Questions *(Please print)*

1. Are you the retiree?
☐ **Yes** Your retirement date *(MM/DD/YYYY)* _____
☐ **No** Name of retiree _____

2. Are you covering a spouse or dependent(s) under this employer or union plan?
☐ **Yes** Name of spouse _____ ☐ **No**
Name(s) of dependent(s) _____

3. Do you or your spouse work? ☐ **Yes** ☐ **No**

4. Will you have other prescription drug coverage in addition to MVP? ☐ **Yes** ☐ **No**
Some individuals may have other drug coverage, including other private insurance, Worker's Compensation, VA benefits, EPIC (NY), or V-Pharm (VT).
If ***Yes***, refer to the ID card for your other drug coverage and provide the following:

Name of Other Coverage			Effective Date
Rx ID No.	**Rx Group No.**	**Rx BIN No.**	**Rx PCN**

5. Are you a resident in a long-term care facility, such as a nursing home? ☐ **Yes** ☐ **No**
If ***Yes***, provide the following information about the facility:

Name of Institution	Street Address	Phone No. ( )

6. Have you served in the military? ☐ **Yes** ☐ **No**

Please contact the MVP Medicare Customer Care at **1-800-665-7924** if you need information in a language other than English, or in an accessible format. Call seven days a week, 8 am–8 pm. April 1–September 30, call Monday–Friday, 8 am–8 pm. TTY: 1-800-662-1220.

Step 6: Read the Following, and Provide Your Signature and Authorization

Release of information: By joining this Medicare health plan, I acknowledge and consent to the release, use, and disclosure of my information (which may include prescription information, medical information, HIV, mental health, and /or alcohol and substance abuse information) by MVP or any health care provider involved in caring for me to Medicare,MVP, or any health care providers, or organizations involved in my care, and other plans as is reasonably necessary for MVP or my health care providers to carry out treatment, payment, or health care operations, or as otherwise and to the extent permitted by, and in accordance with, applicable laws, regulations, and rules. I also acknowledge that MVP may release my information, including my prescription drug event data, to Medicare, who may release it for research and other purposes—to the extent permitted by, and in accordance with, applicable laws, regulations, and rules. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

By providing my email address, I give permission for MVP to send me emails related to my plan and benefits. I understand that I am entitled to receive paper documents, and that I can set and change my communication preferences at any time by signing in at **mvphealthcare.com** and selecting *Communication Preferences* or by calling MVP at **1-800-TALK-MVP** (1-800-825-5687).

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the State where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment; and 2) documentation of this authority is available upon request from Medicare.

Please sign below.

Signature **Today's Date**

If you are the authorized representative, you must sign above and provide the following information about yourself.

Name	Relationship to Enrollee
Address	Preferred Phone No. ( )

Office Use Only

Name of Staff Member/Agent/Broker *(if assisted in enrollment)* | Plan ID No. | Effective Date of Coverage

ICEP/IEP | AEP | SEP (type) | Not Eligible | Agent License No.